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Would you really recommend it?

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4
5 **Abstract**

6 Medical tourism (MT) is a valuable component of many national service economies.
7 Understanding the marketing and recruitment of MT patients is therefore an important
8 consideration for MT providers. Research shows that word of mouth (WoM) remains the most
9 important acquisition channel in this sector. Yet, there is only a limited understanding of
10 antecedent factors behind a patient referral. We develop a framework for WoM, finding support
11 for tourism factors, service quality and perceived value as key antecedents on WoM referrals.
12 We further extend the MT literature by integrating a novel perspective on value creation that
13 surfaces the experiences of frontline service providers for the first time. This paper incorporates
14 two complementary studies, one with a focus on value creation, the other on perceived value.
15 By combing the two in a mixed-methods approach, we emphasise the role of service delivery
16 on WoM. Several implications can be drawn from the study's findings.

17
18 **Keywords:** Medical Tourism; word of mouth; mixed methods; Iran
19
20

1. Introduction

Medical tourism (MT) is an increasingly valuable component of many national service economies (Connell, 2013). Across both developed and developing contexts, medical care has been successfully packaged and marketed towards cross-border consumers (Connell, 2006; Han, 2013). The scope of such MT activity is broad and inclusive; services offered range from bariatric care and fertility treatment to a range of cosmetic and non-essential procedures. The driving factors behind medical tourists seeking overseas treatment are varied, and encompass quality (Lu, Wu, & Chen, 2016), value (Wang, 2012), speed of access to care and even tourism involvement relating to the destination of the medical facility (Crooks et al., 2011). The overall MT sector is significant and growing, with predictions that by 2027 it will reach USD 207.9 billion (Market Analysis Report, 2020).

While the research field examining health and medical tourism has expanded considerably (Connell, 2013), theoretical understanding of economic and marketing issues are recognised as topics requiring further scholarly attention (Chuang, Liu, Lu, & Lee, 2014). One marketing aspect of MT that remains notably underexplored relates to the recruitment of patients. To date, only a limited body of research has examined the configurations of marketing channels and business development practices utilised by medical providers to participate in competitively intensifying global marketplaces (Abubakar & Ilkan, 2016; Yeoh, Othman, & Ahmad, 2013).

Prior research has found that an individual patient's intention to choose a particular medical service provider is related to the service and destination offer (Connell, 2006; Heung, Kucukusta, & Song, 2011; Moghimehfar & Nasr-Esfahani, 2011; Smith & Forgione, 2007). Other research has focused on the importance of 'perceived value' on an individual's post-operative evaluations of their experience. This is shown to predict individuals favourable/unfavourable intentions to refer that experience to others and provides an insight into the benefits MT consumers derive from the service (Han & Hwang, 2013; Han & Hyun, 2015; Lee, 2010). While this research offers valuable insight into MT, it has not yet offered an integrated analysis of MT decision-making and patient recruitment, nor has it advanced a MT provider perspective on how value is created by those interacting with patients at MT hospitals.

This paper extends existing research by developing two complementary studies that seek to theorise the drivers of WoM in a MT context. In study one, we examine value creation through service delivery in MT facilities. Owing to the underexplored nature of value creation (O'Cass & Sok, 2015; Taheri, Coelho, Sousa, & Evanschitzky, 2017) in this context, we utilise an inductive approach to explore ways in which MT staff (both clinical and non-clinical) navigate organisational tensions to provide a positive experience for patients (which will influence likelihood of a WoM referral). Study two examines how patients perceive value following their treatment and tourism experience. We link the outcomes of this evaluation to the likelihood of them providing a WoM recommendation for the MT facility. Then, in our discussion, we integrate the findings of study one and two to emphasise the role of service delivery on WoM. Our research questions are thus:

RQ1: How is value created through service delivery within a MT hospital and what organisational factors influence MT patient experience?

RQ2: What effect do the expectations and experiences of MT have on WoM referrals?

To address these questions, we conduct a two-stage mixed-methods study based at a leading private hospital in north-west Iran. We draw on in-depth qualitative interview data from 61 medical and support staff (study 1) and survey data from 785 medical tourism patients (study 2). We find support for country environment, tourism destination, medical tourism

71 costs/facilities and services as important in the perceived value of MT choices, and ultimately,
 72 the likelihood of referring this service to others. We explore for the first time both the MT
 73 patient and those involved in service delivery at the MT destination. The analysis highlights
 74 novel findings relating to role tensions within MT facilities and threats to medical professional
 75 identities, that can manifest in the overall service experience of patients. Finally, we raise some
 76 practical implications for MT providers by considering the significance of balancing
 77 destination involvement with medical care provision and the likelihood of WoM referrals as
 78 competition intensifies within the sector.

79

80 **2. Literature review**

81

82 *2.1 Medical Tourism*

83

84 There are a number of definitions of the term ‘medical tourism’ in the literature, but
 85 nearly all centre around the notion of travel, usually abroad, with the dual intentions of seeking
 86 medical care and holiday-making (**Table 1**). Most research has focused on the motivations of
 87 those undertaking medical tourism, the ‘medical tourists’ (see Connell, 2006; Heung et al.,
 88 2010; Ghosh & Mandal, 2019; Mathijssen, 2019; Yu & Ko, 2012 amongst others). Key drivers
 89 for this type of activity can be broadly grouped into factors related to cost, accessibility, and
 90 broader factors related to the tourism pull of the country of destination. Research has also
 91 examined the motivations of medical healthcare providers and the wider tourism industry in
 92 promoting medical tourism (Goodrich & Goodrich, 1987). Mathijssen (2019, p. 374), for
 93 example, categorises a range of factors for medical tourists travelling aboard for a treatment,
 94 including:

95

96 “...the relative price of domestic treatment (broadly defined as ‘cost saving’); the
 97 relative waiting time of the domestic treatment (‘long waiting lists’); quality of
 98 healthcare; diversity of facilities and choice; inadequate or non-existent insurance;
 99 ability to maintain anonymity and maintain privacy; cultural affinity in terms of
 100 language, norms, religion, food; access to the latest technologies and treatments;
 101 unavailable (‘circumvention tourism’) or unaffordable procedures in their own
 102 countries; distrust and unfamiliarity with healthcare systems of receiving country; [and
 103 the] added benefit of a holiday.”

104

105 **Table 1**

106 Summary of main definitions of medical tourism.

Source	Definition	Focus	Method	Sample and Region	Conceptualisation/Theoretical Framing	See also
Connell (2006, p. 1094)	“where people often travel long distances to overseas countries to obtain medical, dental and surgical care while simultaneously being holidaymakers.”	Motivations for medical tourists in Asia	Discussion piece - conceptual	Multi - country	Not stated	Garcia-Altes, (2005)

Goodrich and Goodrich (1987, p. 217)	“The attempt on the part of a tourist facility or destination to attract tourists by deliberately promoting its health-care services and facilities, in addition to its regular tourist amenities”	Exploration of the concept of healthcare tourism	Survey and content analysis of marketing material	206 tourists, 22 travel agents, 12 medical doctors, 2 herbalists, 24 countries	Not explicitly stated	n/a
Heung, Kucukusta, and Song (2011, p. 236)	“vacation that involves traveling across international borders to obtain a broad range of medical services. Medical tourism usually includes leisure, fun and relaxation activities, as well as wellness and health-care service.”	Conceptual model of medical tourism	Conceptual	Not stated	Critique of previous two-stage; distribution channel; and motivation models. Presents integrated supply and demand side model.	Smith & Forgione (2007); Ye, Yuen, Qiu, & Zhang (2008)
Reddy, York, and Brannon (2010, p. 511)	“The act of travelling abroad for healthcare”	Student’s perspectives of medical tourism	Student survey	336, U.S. undergraduates	Theory of Planned Behaviour	de la Hoz-Correa, Munoz-Leiva, and Bakucz (2018)
Wongkit and McKercher, 2013, p. 5	“The travel of people to a specific destination to seek medical help that forms the primary purpose of their trip.”	Motivations of medical tourists seeking treatment in Thailand. Development of a typology	Survey	345 patients in Thailand	Not explicitly stated. Focus on motivations	Cohen (2008); Brotman (2010); Pope (2008)
Yu and Ko (2012, p. 81)	“medical tourism involves not only going overseas for medical treatment, but also the search for destinations that have the most technical	Cross cultural study of medical tourists’ perspectives	Survey	785 Chinese, Japanese and Korean Tourists in Korea	Not explicitly stated. Focus on motivation	Reed (2008)

proficiency, and
which provide it
at the most
competitive
prices,
combination of
services and the
tourism
industry.”

107
108 Yu and Ko (2012, p. 82) suggest “medical tourism is conceptually full of nuances,
109 contradictions and contrasts,” leading to a lack of construct clarity (Crompton, 1992; Fetscherin
110 & Stephano, 2016; Ghosh & Mandal, 2019; Mathijssen, 2019). Some scholars emphasise the
111 medical aspect of MT, suggesting that we should refer to medical examinations that take place
112 abroad rather than medical ‘tourism’ (Connell, 2013; Ghosh & Mandal, 2019; Johnston,
113 Crooks, & Snyder, 2012; Mathijssen, 2019; Nahai, 2009; Uchida, 2015). In doing so, they argue
114 that “those who travel internationally are patients, not tourists for shopping and a pleasurable
115 holiday” (Uchida, 2015, p. 19). Others, argue that tourism factors are in fact a key component
116 of the MT destination choice, though note the balance of decision making will vary from
117 individual to individual, and will be influenced by the type of medical procedure they are
118 choosing to undergo (Cohen, 2008; Fetscherin & Stephano, 2016; Lovelock & Lovelock, 2018;
119 Wongkit & McKercher, 2013).

120 121 *2.1.1 Medical Tourism in Iran*

122
123 Tourism in the Middle East in general is one of the least studied sectors in the world,
124 and there is very limited coverage in international tourism literature (Seyfi & Hall, 2018). A
125 long history of political instability in Iran has negatively affected the development of its
126 tourism industry despite its substantial natural, historical and cultural resources (Seyfi & Hall,
127 2018). In addition, there is some debate within Iran as to the merits of encouraging tourism,
128 with differences between reformists and fundamentalists as to whether it presents an
129 opportunity or a threat (Baum & O’Gorman, 2010). That said, since 2010 there has been a
130 focus on the promotion of tourism as a way of reducing dependence on oil export revenues
131 (Jabbari, Zarchi, Kavosi, Shafaghat, & Keshtkaran, 2013; Momeni, Janati, Imani, &
132 Khodayari-Zarnaq, 2018).

133 One area of particular focus has been medical tourism. Since 2010 this sector has had
134 a growth rate of 20-25% (ICHTO, 2018). The Government’s fifth economic development plan
135 (2017-2022) has a strategic target of an increase in revenue from health tourism to \$2.5 billion
136 and to increase the numbers of health tourists by 600,000 per annum (Momeni et al., 2018).
137 There are a number of factors that will facilitate this growth and the increasing development of
138 the sector. Iran is geographical proximate to a large number of other countries making it an
139 easily accessible location (Momeni et al., 2018). It is bordered to the south by Azerbaijan,
140 Armenia and the Arabic countries of UAE, Qatar, Bahrain, Saudi Arabia, Kuwait and Oman.
141 Pakistan and Afghanistan sit on its east, to the east, Turkmenistan to the north and Turkey and
142 Iraq to the west.

143 Iran is internationally renowned medical services and staff with expertise in organ
144 transplant and aesthetic surgery (Momeni et al., 2018; Seyfi & Hall, 2018). Its services are
145 relatively low cost in comparison with other competitor markets (Seyfi & Hall, 2018) and it
146 also has relatively short waiting times for treatments (Jabbari et al., 2013). However, there are
147 challenges to the development of the sector, including insufficient numbers of medical centres
148 and a lack of integrated support services such as marketing and travel agencies to facilitate

149 international tourist uptake of the medical services on offer (Azadi, Maleki, Tabibi, & Azmal,
150 2012).

151
152 *2.2 Word of Mouth*
153

154 While MT research has confirmed that WoM influences customer acquisition and
155 retention (Han & Hyun, 2015; Yeoh et al., 2013), there is no detailed understanding of what
156 drives a referral in the MT context. Empirical evidence suggests that MT consumers are largely
157 influenced by a WoM recommendation from friends and family (e.g., Musa, Thirumoorthi &
158 Doshi, 2012), with the internet being only a secondary influencer (e.g., Chuang et al., 2014;
159 Connell, 2013). Connell (2013) argues that, as MT develops, WoM is becoming more
160 important, with online channels serving largely functional roles in the checking of facts and
161 booking treatment packages.

162 WoM is a well-established concept in marketing literature, with significant theoretical
163 development that draws upon cognitive, emotional and interactionist perspectives (Berger,
164 2014; Gannon, Taheri, & Olya, 2019; De Matos & Rossi, 2008). The most widely accepted
165 definition of WoM is as “informal communications directed at other consumers about the
166 ownership, usage, or characteristics of particular goods and services and/or their sellers”
167 (Westbrook, 1987, p. 261). WoM is influential in-service sectors such as medical tourism,
168 owing to the intangible and experiential nature of product offerings (Zeithaml, Berry, &
169 Parasuraman, 1993). Empirical evidence has shown that WoM referrals provide a means of
170 reducing the risk inherent to such transactions (Musa et al., 2012).

171 Research into the antecedents of WoM in a MT context has been limited and there have
172 been repeated calls for more analysis (cf. Alves et al., 2016; Fernandes & Fernandes, 2017;
173 Han, Meng, & Kim, 2017; Harrigan, Evers, Miles, & Daly, 2017; Wardi, Abror, & Trinanda,
174 2018). Existing studies have typically focused on the direct effects of consumer satisfaction
175 and dissatisfaction (Brown, Barry, Dacin, & Gunst, 2005). Others have focused on a limited
176 number of key constructs such as perceived value, service quality or customer commitment
177 (see **Table 2**). In the most comprehensive review to date, of 127 quantitative studies of
178 antecedents of WoM, de Matos and Rossi (2008) find support for a direct effect of commitment,
179 perceived value, quality, trust, satisfaction and loyalty on WoM.

180
181 **Table 2**
182 **Multidisciplinary definitions of WoM.**

Source	Discipline	Definition	Antecedents
Brown et al. (2005)	Relationship Marketing	WoM communication includes any information about a target object (e.g., company, brand) transferred from one individual to another either in person or via some communication medium.	Satisfaction, commitment
Carroll and Ahuvia (1982)	Marketing	After Westbrook (1987) “as the degree to which the consumer praises the brand to others” (Carroll & Ahuvia, p. 84).	Brand love
DeMatos and Rossi (2008)	Marketing	“informal communications directed at other consumers about the ownership, usage, or characteristics of particular goods and services and/or their sellers” (Westbrook, 1987, p. 261).	Satisfaction, loyalty, quality, commitment, trust, perceived value

		“oral, person-to-person communication between a perceived non-commercial communicator and a receiver concerning a brand, a product, or a service offered for sale” (Arndt, 1967, p. 190).	
Fillieri and McLeay (2013)	Consumer Behaviour	E-WoM has been defined as “any positive or negative statement made by potential, actual or former customers about a product or company, that is made available to a multitude of people and institutions via the internet” (Hennig-Thurau et al., 2004, p. 39).	Not addressed
Harrison-Walker (2001)	Services Marketing	Favourable WoM may include “relating pleasant, vivid, or novel experiences; recommendations to others; and even conspicuous display” (Anderson, 1998, p. 6). WoM may be defined as informal, person-to -person communication between a perceived non-commercial communicator and a receiver regarding a brand, a product, an organisation, or a service (Anderson, 1998; Arndt, 1968; Buttle, 1998).	Service quality and customer commitment
Litvin et al. (2008)	Tourism Management	“all informal communications directed at other consumers about the ownership, usage, or characteristics of particular goods and services and/or their sellers” (Westbrook, 1987, p. 261)	Not explicitly addressed, but satisfaction discussed as key antecedent

183

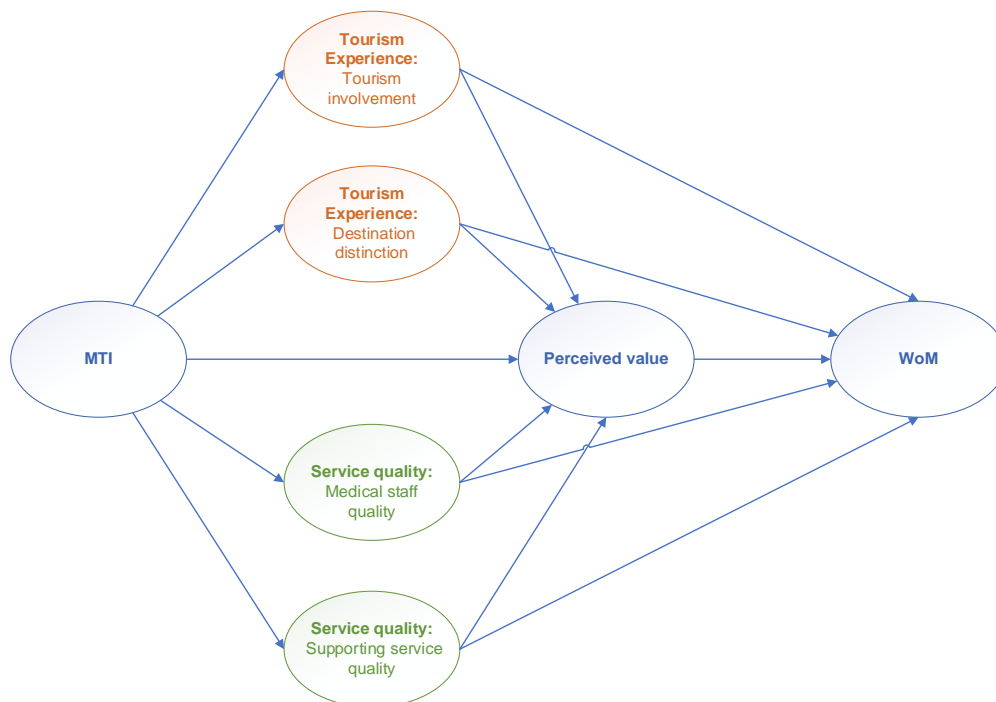
184 *2.3 Conceptual model*

185

186 O’Cass and Sok (2015, p. 187) argue that “...value is created at the point of proposition
187 by the firm, while perceived use value... is subjectively assessed by the customer, and
188 exchange value is realised at the point of exchange via firm–customer interaction.” Here,
189 “customers assess the value creation through their views of what is given, how it is participated
190 and what is expected” (Taheri et al., 2017, p. 3065). To this end, we evaluate how medical
191 tourists perceive value following their treatment and their tourism experience by linking the
192 outcomes of their value evaluation to the likelihood of them providing a WoM
193 recommendation.

194 Our conceptual research model presented in **Fig. 1** therefore proposes the effect of
195 medical service quality (medical staff quality and supporting service quality) and tourism
196 experience (tourism involvement and destination distinction) on perceived value and WoM.
197 We developed the conceptual framework shown in **Fig. 1** based on a review of the WoM
198 literature, relating this specifically to the MT context. Drawing on MT literature we argue that

199 the intention of patients to refer a MT provider to others through WoM referrals, is related to
 200 their perceptions of value following a treatment, based on both service experience and
 201 expectations of that experience prior to treatment. In a MT context, we propose that this
 202 perception of value is derived from both factors related to the service quality provision and
 203 overall tourism experience. We also propose that these factors in themselves may have a direct
 204 effect on the likelihood of WoM referrals. The theoretical rationale for the relationships
 205 proposed in the conceptual model is discussed in following sections.
 206



207
 208 **Fig. 1.** Conceptual model

209
 210 *2.3.1 Antecedents of WoM*

211
 212 *2.3.1.1 Perceived Value*

213
 214 Marketing literature highlights the important role of perceived value in a patient's
 215 intention to refer a service to others through WoM (Sanchez-Fernandez & Iniesta-Bonillo,
 216 2007; Sweeney & Soutar, 2001; Zeithaml, 1988). Perceived value can be defined as the
 217 “consumer’s overall assessment of the utility of a product (or service) based on perceptions of
 218 what is received and what is given” (Zeithaml, 1988, p. 14). It is based on a trade-off between
 219 the quality, or benefits, customers receive from a service, and a customers’ sacrifices to obtain
 220 such quality/benefits (Monroe, 1990; Oh, 2000; Yang & Peterson, 2004; Zeithaml, 1988).
 221 Within the tourism literature it has been identified as a key component in the choice of one
 222 destination over another (Han & Hyuan, 2012; Lee, 2010). However, there has been limited
 223 empirical research on the importance of perceived value on behavioural intention within the
 224 medical tourism literature. In one of the few studies examining the impact of perceived value
 225 on medical tourism choice, Han and Hwang (2013) found that perceived value was
 226 significantly related to the perceived benefits of a medical hotel and that perceived value
 227 positively affected behavioural intentions. In particular, they found that increases in financial
 228 savings, convenience and medical service lead to an increase in tourist’s perceptions of high
 229 perceived value in the medical tourism hotel. This meant that medical tourists would be willing
 230 to visit, and critically, would recommend it to others.

231 2.3.1.2 *Service Quality*

232

233 Drawing on wider service literature (Gannon et al., 2019; Zeithaml, 1988; Zeithaml et
234 al., 1993), we propose that perceptions of medical service quality will have a direct effect on
235 WoM, and it will have an indirect effect through perceptions of value. Here, service quality
236 can be defined as “the outcome of a process in which consumers’ expectations for the service
237 are compared with their perceptions of the service actually delivered” (Mangold & Babakus,
238 1991, p. 60). Thus, perceptions of quality are implicitly related to expectations (Zeithaml et al.,
239 1993). There has been less focus on medical service providers than consumers within the
240 medical tourism field, but most who have explored this area have adapted the well-known
241 SERVQUAL scale to evaluate service standards in medical tourism (Debata et al., 2015; Guiry
242 & Vequist, 2011; Manaf et al., 2015; Wang, 2012). This scale identifies five key quality
243 dimensions related to the physical facilities of the service provider: the reliability and
244 dependability of the service; the responsiveness of the service provision and willingness to help
245 customers; assurance of employees in terms of knowledge and courtesy; empathy in terms of
246 care provision; and finally, individualised attention (Zeithaml, Bitner, & Gremler, 2009;
247 Parasuraman, Zeithaml & Berry, 1988; 1991).

248 These dimensions can be further grouped into those related to medical staff quality;
249 those supporting services quality; and those related to administrative services quality (Abd
250 Manaf et al., 2015; 2017; Fetscherin & Stephano, 2016; Heung et al., 2011; Moghavvemi et
251 al., 2017; Smith & Forgione, 2007). Empirical research evidences that they are important
252 dimensions in terms of patient satisfaction, perceived value and future intention for treatment,
253 with medical staff quality highlighted as the most important factor of the three (Heung et al.,
254 2011; Mattoo & Rathindran, 2006).

255

256 2.3.1.3 *Tourism Experience*

257

258 We propose that the tourism experience will have a direct effect on WoM referrals and
259 an indirect effect again through perceived value. As discussed above, tourism factors are a key
260 part of the cognitive decision-making process for medical tourists (Cohen, 2008; Fetscherin &
261 Stephano, 2016; Lovelock & Lovelock, 2018; Wongkit & McKercher, 2013). The overall
262 image of a country has been shown to be a key factor in choice as a tourist destination, and this
263 factor applies to the MT context as well (Beerli & Martin, 2004; Gallarza, Saura, & García,
264 2002). The importance of tourism-specific factors has been highlighted by other research in
265 this area, with scholars noting cultural and natural attractions, weather and attractiveness,
266 popularity, and exoticness as a tourist destination as important dimensions (Fetscherin &
267 Stephano, 2016; Lovelock & Lovelock, 2018). Tourism “involvement is ... described as the
268 state of motivation and desire towards an activity or an associated item” (Lu et al., 2015, p.
269 88). Involvement has been measured as both a unidimensional and multidimensional concept
270 and opinions on the preferred number of dimensions remain mixed. However, studies concur
271 that personal interest is an important factor, and all current conceptualisation includes this
272 dimension (Gursoy & Gavcar, 2003; Lee & Beeler, 2009; Lu et al., 2015). Numerous studies
273 have highlighted the importance of tourism involvement in tourist’s evaluations of their
274 activities and their future behavioural intentions (Funk, Ridinger, & Moorman, 2004; Gursoy
275 & Gavcar, 2003; Lu et al., 2015; Hwang, Lee, & Chen, 2005; Lee & Beeler, 2009). Several
276 studies have found involvement to be a significant predictor of satisfaction and future intention
277 (Kim, Kim, & Kim, 2009; Lee & Beeler, 2009).

278 The literature on destination distinctiveness draws on place branding, destination
279 marketing and tourism destination image (Beerli & Martin, 2004; Gallarza et al., 2002; Pike &
280 Page, 2014; Viladrich & Baron-Faust, 2014). Tourism destination image is a set of beliefs,

281 ideas and impressions generated by tourists (Crompton, 1979), and can be defined as “all that
282 the destination evokes in the individual; any idea, belief, feeling or attitude that tourists
283 associate with the place” (Alcañiz, García, & Blas, 2009, p. 716). It has been shown to influence
284 the cognitive evaluation and subsequent decision-making in relation to destination choice (Lu
285 et al., 2015). It has both cognitive and affective components comprising the tangible properties
286 of a destination and prospective tourists’ feelings and evaluations towards that destination (Pike
287 & Ryan, 2004; Wang & Hsu, 2010).

288 The branding of a destination as distinctive, is a way of communicating a uniqueness
289 that sets it apart from its competitors (Pike & Page, 2014; Qu, Kim, & Im, 2011). The
290 perception of this distinctiveness by tourists gives a location a competitive advantage that is
291 notionally difficult for others to replicate. In turn this will increase its attractiveness vis-a-vis
292 other locations and has been shown to lead to positive intentions to both purchase (Currás-
293 Pérez, Bigné-Alcañiz, & Alvarado-Herrera, 2009) and to refer to others (Qu et al., 2011).
294 Studies have shown the strong relationship between destination distinctiveness and place
295 dependence (Brocato, Baker, & Voorhees, 2015), tourist revisit intentions and intentions to
296 spread positive WoM (Chi & Qu, 2008).

297 Studies have also shown distinctiveness to be an influential factor in both pre-purchase
298 decision-making and post-purchase evaluation of the perceived value of an experience and the
299 likelihood of referring a service to others (Brocato et al., 2015; Viladrich & Baron-Faust, 2014).
300 In a recent qualitative study of the touristic component of cognitive decision-making in relation
301 to medical tourists, Lovelock and Lovelock (2018) found some influence of destination
302 distinctiveness on destination choices, particularly in relation to key low culture destination
303 attributes such as beaches, shopping and relaxation activities.

304 305 *2.3.1.4 Medical Tourism Index*

306
307 Finally, we suggest that the expectations around the attractiveness of a country as a MT
308 destination will influence tourism experience and service quality during the actual service
309 encounter. This in turn will affect perceived value and WoM. These expectations will also have
310 a direct effect on perceptions of MT perceived value. These expectations consist of factors
311 related to both the medical and tourism experience, and the overall environment and image of
312 the MT destination country. Prior research has argued that an individual patient’s intention to
313 choose a particular medical service provider is related to three key factors: the overall
314 environment of the particular country of choice; that country’s healthcare and wider tourism
315 industries; and, the specific quality of the medical facility and associated services (Connell,
316 2006; Heung, Kucukusta, & Song, 2011; Moghimehfar & Nasr-Esfahani, 2011; Smith &
317 Forgione, 2007). Most recently, these factors have been successfully conceptualised as the
318 Medical Tourism Index (MTI) (Fetscherin & Stephano, 2016). The overall image of a country
319 has been shown to be a key factor in choice as a tourist destination and this factor also relates
320 to choose for MT (Beerli & Martin, 2004; Gallarza, Saura, & García, 2002). In addition to
321 image, other key country-related factors include the political and economic environment
322 (Connell, 2006; Smith, Álvarez, & Chanda, 2011; Yu & Ko, 2012) and; cultural similarity and
323 cultural distance (Lee & Davis, 2005; Yu & Ko, 2012). The importance of tourism specific
324 factors has been highlighted by other research, such as: cultural and natural attractions; weather
325 and attractiveness; popularity and; exoticness as a tourist destination (Fetscherin & Stephano,
326 2016; Lovelock & Lovelock, 2018).

327 The rapid development of MT and the concomitant access to advanced medical
328 technology has meant that the medical infrastructure and systems used by private hospitals has
329 developed rapidly and healthcare costs reduced. The relatively lower costs of accessing medical
330 treatment abroad has been found to be a key driver of medical tourism (Connell, 2006; Smith

331 & Forgione, 2007; Yu & Ko, 2012). The quality of medical facilities and services have also
332 been shown to be key factors in the decision to choose particular medical service providers
333 (Abd Manaf et al., 2017; Fetscherin & Stephano, 2016; Heung et al., 2011; Moghavvemi et al.,
334 2017; Smith & Forgione, 2007). Some elements are related to the quality of the actual facility
335 in terms of reputation, accreditation and medical equipment (Connell, 2006; Heung,
336 Kucukusta, & Song, 2011; Moghavvemi et al., 2017; Smith & Forgione, 2007; Yu & Ko,
337 2012). Others relate to the quality of care given by medical staff and their medical reputation
338 (Berkowitz & Flexner, 1980; Heung et al., 2011; Manaf et al., 2017; Mattoo & Rathindran,
339 2006).

340

341 **3. Methodology**

342

343 To answer our research questions, we adopted a two-stage explanatory design approach
344 combining quantitative and qualitative data (Alexander, MacLaren, O’Gorman, & Taheri,
345 2012; Creswell & Creswell, 2018; Teddlie & Tashakkori, 2009). The combination of
346 quantitative and qualitative methods offers more insightful and more complex answers to
347 research questions compared to either of them alone; it further provides a platform for
348 integrating quantitative accuracy with narrative complexity (Creswell & Creswell, 2018;
349 Teddlie & Tashakkori, 2009). For our first study, a series of semi-structured interviews were
350 conducted with medical and support staff at a leading private hospital in north-west Iran. The
351 objective of this study was to examine the complex nature of value creation (O’Cass & Sok,
352 2015; Taheri et al., 2017) through ongoing service delivery by clinical and non-clinical
353 employees. This was followed by a second study, which was operationalised through a survey
354 of in-patients at the same hospital, exploring their reasons for choosing this service provider
355 and their experiences whilst there.

356

357 *3.1 Research Context*

358

359 The Iranian health system has been subject to various reforms over the past three
360 decades. According to the Constitution of the Islamic Republic of Iran, every Iranian should
361 enjoy the highest level of healthcare and medical service. There is public (over 90% of
362 treatment costs covered by the state) and private healthcare (which remains at a lower cost than
363 neighbouring countries such as Azerbaijan, Iraq, Turkey, India and Pakistan). Both healthcare
364 systems are monitored by Ministry of Health and Education (MOHME) of Iran who are
365 responsible for supervision and regulations in health care service. Iran has over 800 medical
366 establishments with over 120,000 beds in all, of which 550 are managed by the MOHME and
367 250 are privately owned (AMAR, 2016). There are 0.7 beds per 1,000 people in Iran.

368 The hospital which formed the focal organisation in our study is one of the most
369 internationally recognised private hospitals in Western Asia. It is noted for a range of service
370 factors including cheaper treatment, highly qualified staff and doctors, and a picturesque travel
371 destination in the north-west of Iran (AMAR, 2016).

372

373 *3.1 Qualitative study*

374

375 *3.1.1 Data gathering*

376

377 In total we undertook 61 semi-structured interviews with full-time employees of a
378 single MT hospital in Iran (see **Table 3**). The interviews were conducted in the months of
379 February and March 2016. The study deployed two complementary sampling strategies:
380 purposive and snowball sampling (Ritchie, Lewis, & Elam, 2003; Wells, Gregory-Smith,

381 Taheri, Manika, & McCowlen, 2016a). Purposive sampling facilitated the identification of
 382 appropriate participants for the study, while snowball sampling allowed selected individuals to
 383 identify others that they knew to be information-rich as the research progressed (Lincoln &
 384 Guba, 1985). Our intention was to gather a representative range of respondents that broadly
 385 reflected the various jobs families within the hospital (e.g., clinical, management,
 386 administrative, tourism-related, marketing and service/maintenance/cleaning). Our final
 387 sample achieved a good balance, albeit it was skewed slightly towards clinical respondents,
 388 largely owing to their more detailed knowledge of MT, and their willingness to discuss matters
 389 candidly and on-the-record.

390 All interviews were undertaken by a native speaker (of both Farsi and English
 391 languages), a member of the research team. The interviews were audio-taped and transcribed
 392 verbatim, and confidentiality of participants was assured. In order to maintain the anonymity
 393 of participants and the organisation, identifying details have been modified and pseudonyms
 394 are used throughout this research. The interviews were semi-structured and alternated between
 395 short intercept-style interviews to longer in-depth interviews. The first five individual
 396 interviews took the form of open-ended ‘chats’, as we aimed to construct a bigger picture of
 397 the hospital employees’ view on their daily work and interactions with one another (Hudson &
 398 Ozanne, 1988; Jafari, Taheri, & vom Lehn, 2013). We then added further questions to
 399 subsequent participant interviews based on our literature review findings, specifically around
 400 those themes relating to service quality, service delivery, destination distinction and tourism
 401 involvement. We encouraged further insights by asking open questions around the more
 402 general experiences of working in a MT facility. From these open questions we discovered
 403 tensions between commercial (i.e. revenue-generating) and care-giving provision, and
 404 accordingly we incorporated this theme in to ensuing interviews with respondents. Our
 405 participants were encouraged to illuminate their views with specific workplace examples,
 406 stories and personal narratives (Jafari et al., 2013).

407

408 **Table 3**

409 Interview participants profile.

ID	Organisational role	Sex	Age
1	Nurse	Male	20-30
2	Frontline staff	Male	31-40
3	Doctor	Male	41- 50
4	Hospitality	Female	20-30
5	Frontline staff	Female	20-30
6	Technical support	Male	31-40
7	Clinical support	Male	31-40
8	Nurse	Female	20-30
9	Nurse	Female	31-40
10	Nurse	Male	31-40
11	Clinical support	Male	20-30
12	Non-clinical support	Male	51 and over
13	Clinical support	Female	31-40
14	Technical support	Male	51 and over
15	Non-clinical support	Male	20-30
16	Non-clinical support	Male	51 and over
17	Nurse	Female	20-30
18	Clinical support	Male	41- 50
19	Nurse	Female	31-40
20	Hospitality	Male	20-30

21	Clinical support	Male	31-40
22	Nurse	Female	31-40
23	Clinical support	Male	41- 50
24	Nurse	Female	20-30
25	Doctor	Female	31-40
26	Frontline staff	Female	51 and over
27	Hospitality	Female	31-40
28	Technical support	Male	20-30
29	Doctor	Male	31-40
30	Clinical support	Male	41- 50
31	Frontline staff	Female	51 and over
32	Technical support	Male	20-30
33	Frontline staff	Male	51 and over
34	Technical support	Male	31-40
35	Clinical support	Female	20-30
36	Technical support	Male	51 and over
37	Nurse	Female	41- 50
38	Hospitality	Male	20-30
39	Clinical support	Female	51 and over
40	Frontline staff	Male	51 and over
41	Doctor	Female	41- 50
42	Nurse	Male	31-40
43	Non-clinical support	Male	20-30
44	Clinical support	Male	51 and over
45	Technical support	Male	51 and over
46	Doctor	Male	41- 50
47	Nurse	Female	41- 50
48	Hospitality	Female	31-40
49	Nurse	Female	20-30
50	Doctor	Male	41- 50
51	Clinical support	Male	20-30
52	Nurse	Male	51 and over
53	Frontline staff	Female	20-30
54	Clinical support	Male	51 and over
55	Technical support	Male	51 and over
56	Hospitality	Female	20-30
57	Technical support	Male	51 and over
58	Clinical support	Male	41- 50
59	Frontline staff	Female	20-30
60	Doctor	Male	41- 50
61	Clinical support	Male	20-30

410

411 *3.1.2 Data analysis*

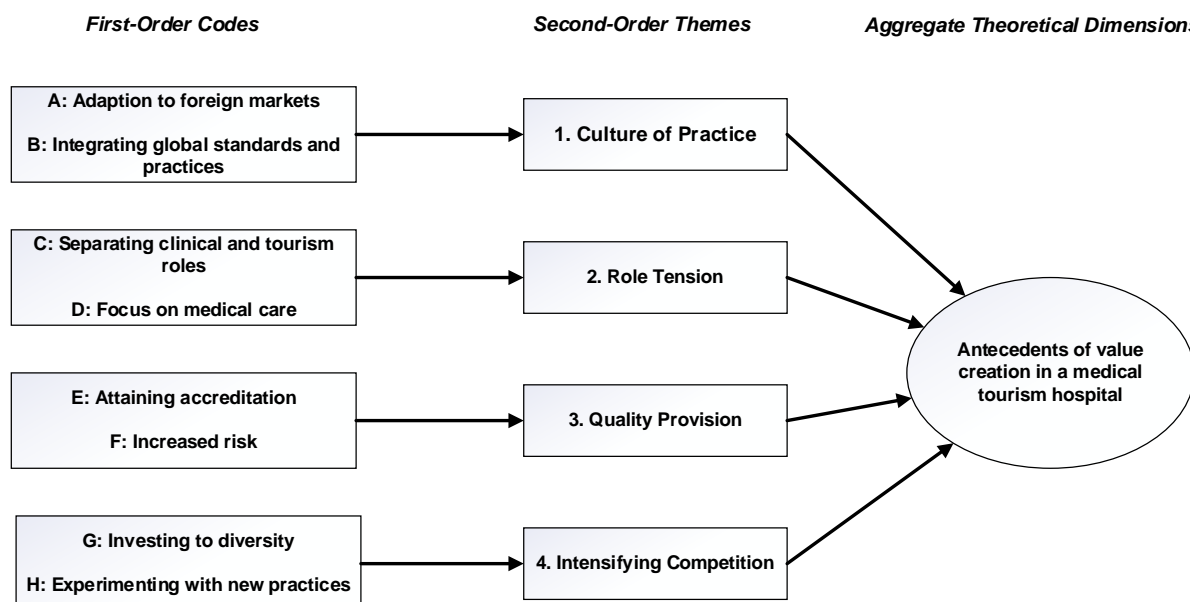
412

413 We followed the approach developed by Gioia, Corley and Hamilton (2013) to generate
414 findings around phenomena of interest by using research subjects' own words. With this in
415 mind, the first step in the analysis was to transcribe each interview (verbatim) after it had taken
416 place. Across the 61 interviewees more than 60 hours of audio were recorded with
417 transcriptions amounting to over 1,000 double-spaced pages. Furthermore, field notes and
418 memos were taken during and after the interviews and were triangulated with the audio to

419 strengthen the validity and credibility of the research (Miles & Huberman, 1994). After this
 420 initial step, we manually coded our data and identified empirical themes. We categorised a
 421 series of ‘first order’ codes that reflected broad activities relating to the creation and delivery
 422 of patient value, where key words, phrases, sentences, and paragraphs from the transcripts,
 423 memos, field notes and secondary data were underpinned by our emerging analysis (Miles &
 424 Huberman, 1994).

425 The final stage involved further coding and interpretation through the use of NVivo.
 426 This aided verification of the data, re-coding it where necessary and linking key concepts as
 427 patterns until the relationships among the emerging categories of data became obvious
 428 (Kreiner, Hollensbe, & Sheep, 2006). The template enabled these to be coded and arranged in
 429 a hierarchical fashion to depict the relationship between themes, with the broadest themes at
 430 the top, and more specific second-order themes which included recurring issues relating to:
 431 culture(s) of practice, role tension, quality provision and intensifying competition, and then
 432 first-order sub-themes beneath. This stage of analysis aimed to ensure that the findings
 433 emerging in the first round of coding could be systematically evidenced in the data, thus
 434 ensuring validity. The analysis process was not linear; rather, it proceeded iteratively, moving
 435 between data, emerging patterns, and the literature until the data were refined into adequate
 436 conceptual themes (Eisenhardt, 1989). The resulting data structure is illustrated in **Fig 2**.

437



438

439 **Fig. 2.** Data structure.

440

441 *3.2 Quantitative study*

442

443 A survey was then conducted with international medical travellers who had visited Iran
 444 for medical attention within 6 months in 2016. The questionnaires were distributed to
 445 international patients receiving medical care in the private hospital in the last day of their visit
 446 within the hospital (on site in order to safeguard high response and usability rates). We
 447 designed the questionnaire and provided exact instructions on how data collection should be
 448 undertaken. Patients were approached directly to improve the validity of our study. Using non-
 449 probability judgmental sampling, we only conducted our questionnaire from those travellers
 450 who had previous international medical-tourism experience. As Wells et al. (2016a, p. 67) note:
 451 “this sampling technique has been noted as an effective way of collecting data where the aim
 452 is theoretical advancement rather than generalisation and is used frequently in tourism and

453 hospitality studies”. We prepared several different versions of the questionnaire (English,
454 Azeri, Russian and Arabic), since the majority of the international patients could communicate
455 in one of these languages. We used a back-translation method in order to gain a higher level of
456 consistency and accuracy (Wells et al., 2016b).

457 Out of the 785 respondents, 48.2% (378) were male and 51.8% the rest were female
458 (407). An overwhelming number of participants were in the age range of 18 to 35 years old
459 (46.2%) and 36 to 64 years old (50.1%), and 4.7% were 65 years old and older. The majority
460 of respondent were married or in a relationship (95.9%). Similarly, most participants visiting
461 the hospital with friends or a member of family member (89.4%). 35.4% of the respondents
462 had a college degree, 56.7% a university degree, and 7.9% basic education or high school
463 diploma. In terms of nationality, 59.4% of the respondents come from post-Soviet states or
464 Turkey, 25% from the Persian Gulf, 12% from Europe and the rest from other parts of the
465 world (3.7%). These respondents had been treated for many reasons, including: cancer; heart
466 conditions; kidney-related issues; gynaecological issues; plastic and other cosmetic surgeries
467 in the hospital. All participants stayed in the city between 7 and 14 days. Each questionnaire
468 took approximately 15 minutes to complete.

469 We used the mean replacement technique to overcome missing values across the
470 dataset. This “replaces the missing values for a variable with the mean value of that variable
471 calculated from all responses” (Hair, Black, Babin, & Anderson, 2010, p. 53) and does not
472 change the sample size or mean of variables. According to Tabachnick and Fidell (2013), the
473 mean replacement technique can overcome missing values across the dataset if there are <5%
474 incomplete data. In this study, the percentage of missing values was 1.022%. Garson (2016)
475 also suggests missing values significantly impact structural models when more than 5% of
476 values are missing. Thus, missing values do not have a significant impact in this study. Full
477 details of items, mean values, and standard deviations (SD) under respective constructs are
478 provided in **Table 2**. The values of Skewness and Kurtosis for some scale items did not fall
479 within the acceptable range (± 3), indicating non-normal data distribution (Wells et al., 2016b).

480 To test non-response bias, we compared the early and late participants based on the
481 differences in characteristics. The results indicate no significant differences, yielding that non-
482 response bias was not an issue for our study (Armstrong & Overton, 1977). Finally, we
483 controlled for several variables that could threaten the accuracy of our conceptual model
484 estimation including age, gender, visit group and marital status.

485

486 *3.2.1 Measurement of variables*

487

488 The items of the constructs were adapted from existing scales. All constructs were
489 anchored at 1 = *strongly disagree* and 7 = *strongly agree*. Medical staff quality was measured
490 by 12 items adapted from Abd Manaf et al. (2015). Three items adapted from Lu et al. (2015)
491 measured visitors’ involvement. The perceived value measure included 4 items from Han and
492 Hwang (2013). For measuring destination distinction, four items adapted from Brocato et al.
493 (2015). For supporting service quality, we used 4 items from Abd Manaf et al. (2015). From
494 items on WoM adapted from Maxham and Netemeyer (2002) and Salanova, Agut, and Peiró
495 (2005). Finally, the second-order MTI construct (including for first-order dimensions: country
496 environment (5-item), tourism destination (5-item), medical tourism costs (5-item) and medical
497 facility and services (17-item) borrowed from Fetscherin and Stephano (2016). A pilot
498 questionnaire was conducted with 30 participants and some necessary changes were made to
499 the questionnaire.

500

501 *3.2.2 Analytical technique*

502 Partial least squares structural equation modelling (PLS-SEM) was used as the method
503 of analysis this study for various reasons. (1) PLS-SEM is desired technique for estimating
504 path coefficients in SEM as it does not require normal distribution (Wells et al., 2016a; do
505 Valle & Assaker, 2015). We tested for multivariate normality examination by calculating z-
506 scores for kurtosis and skewness for all items. The findings indicated that some items have the
507 skewness and kurtoses above mandatory cut-off point of -3 and +3 (Hair et al., 2010; Mardia,
508 1970) (**Table 2**). (2) It is a powerful technique for assessing formative, reflective and higher-
509 order models (Hair, Hult, Ringle, & Sarstedt, 2017; Henseler, Ringle, & Sinkovics, 2009; Lee,
510 Hallak, & Sinkovi, 2016). Our model is a combination of higher-order and reflective measures.
511 We followed the suggested two-stage analytical technique including (Chin, 2010; Hair et al.,
512 2017): assessing reliability and validity of the measurement model (reflective models and
513 higher-order model) and examining the structural model, using SmartPLS 3.2.4 software.

514 515 *3.2.3 Common Method Variance*

516
517 As with all self-reported data, there is a potential threat of common method variance
518 (CMV), which may be caused by multiple sources (Liang, Saraf, Hu, & Xue, 2007; Podsakoff,
519 MacKenzie, Lee, & Podsakoff, 2003). In practice, we assured respondents anonymity and
520 confidentiality of their response in order to reduce social desirability bias. We have placed
521 dependent and independent variables in different section of the questionnaire. We used
522 Harman's single-factor. Principal component analysis (PCA) (with varimax rotation) on the
523 questionnaire items presented the existence of 6 distinctive factors (F1: 9.011; F2: 4.315; F3:
524 2.103; F4: 2.002; F5: 1.604; F6: 1.023) with eigenvalue greater than 1, yielding 66.511% of
525 the total variance with the first factor accounting for only 24.1 percent of the total variance
526 (i.e., less than 50% which did not describe most of the variance). We also used the unmeasured
527 method factor approach suggested by Min, Park and Kim (2016) and Liang et al. (2007) to
528 further examine the CMV. The findings indicate that the average substantively explained
529 variance of the indicators is 0.62, while the average method-based variance is 0.089, yielding
530 a ratio of 69:1. Thus, we contend that the CMV is unlikely to be a serious concern for this
531 study.

532 533 **4. Results and discussion**

534 535 *4.1 Qualitative analysis*

536
537 We use our qualitative analysis to answer our first research question, which asks: *How*
538 *is value created within a MT hospital, and what organisational factors influence MT consumer*
539 *experience?* We present our model and data structures in **Fig 2** and **Table 4** respectively and
540 discuss the emergent themes in the following section.

541 542 *4.1.1 Culture of Practice*

543
544 Staff highlighted the importance of culture in shaping how patient value was created
545 within the MT facility. In particular, they noted the cultural specificities of working in Iran,
546 which meant that systems developed elsewhere did not necessarily transpose into this particular
547 context, risk-free (Connell, 2013; Momeni et al., 2018; Fetscherin & Stephano, 2016). This
548 was salient, as the internal culture was being driven by need to emulate perceived 'gold
549 standard' practices imported from various Western healthcare systems.

550 Others noted the effort required by employees in both adapting to external cultures and
551 embedding those cultures within an Iranian context. Interviewees understood the importance

552 of 'cultural match' on the choice of their offer by foreign patients (Lee & Davis, 2005; Yu &
553 Ko, 2012) and talked of the ways in which they had tried to accommodate service users from
554 different cultural backgrounds. However, they also acknowledged that whilst striving to
555 minimise issues related to cultural distance, the measures enacted thus far had not alleviated
556 issues entirely: "*I think the new system is very good, however we could improve it, particularly*
557 *if we want to provide service to our foreign visitors from neighbouring countries!*" (Participant
558 25). Thus, it was recognised that with an increasingly cosmopolitan range of visitors, drawn
559 from both neighbouring countries and further afar, adapting to each patient's cultural
560 expectations and specificities were challenging, in turn contributing to the risk of decreased
561 value creation.

562
563

Table 4

Exemplar data representing analytical codes.

Overarching Dimension: Organisational-level Antecedents of Value Creation in a Medical Tourism Hospital	
1. Culture of Practice	
A. Adaption to foreign markets	A1: "This is a great hospital. We have changed a lot to accommodate our foreign visitors' expectations. We hope that we did a good job here!" (Participant 60).
B. Integrating global standards and practices	B1: "A couple of years ago the government adapted the UK NHS system in Iran with some cultural tweak. That seems like a good one. But, you know, the cultural tweak part sometimes it is not working" (Participant 12).
2. Role Tension	
C. Separating clinical and tourism roles	C1: "As far as I understand the roles and medical services, responsibility for the patient should stay with us during and after the service...I take care of medical treatments and the tourism stuff stays with our medical tourism division. I disappear after my service to my patient... I keep my doctor and patient relationship seriously but I am not a tour guide!... I am sure they will come back to us based on excellent service from our hospital" (Participant 25).
D. Focus on medical care	D1: "I am a doctor. I am not an entertainer. I do my professional job which is taking care of my patients, and I am busy. I cannot put them in the car and drive around...Also, I want to keep my doctor and patient relationship in a way it is supposed to be... I think they appreciate service more than tourism, and I know this as I have several foreign patients... they bring more patients to us... their family and friends I mean" (Participant 60).
3. Quality Provision	
E. Attaining accreditation	E1: "You know if we receive a good recognition from the accreditation body. I think that will impact on our organisation and personally I will feel proud. However, a lot of paperwork is involved! I do not like it - it means more work for us" (Participant 50).
F. Increased risk	F1: "You know for me, some of this control process is good and some is bad. It might help to increase the profit and I cannot think about the negative side of it, but I am sure it has some. Also, you know there are always some fines involved if we do not follow them" (Participant 37).
4. Intensifying Competition	
G. Investing to diversify	G1: "We are not alone in this city. There are a couple of hospitals and health clinics. Some of them provide different health things which we do not have here. But it seems we want to extend our hospital. Hopefully we will cover all different aspects" (Participant 10).
H. Experimenting with new practices	H1: "We have tried to change a lot things in our hospital last several years. We want to get more international visitors. It is a tough business and there is a lot of competition going on at the moment in the city. We are not the only hospital in the city" (Participant 22).

564

565 4.1.2 Role Tension

566

567 An aspect of medical tourism that has been overlooked in extant literature is the role-
568 tension that employees, particularly on the clinical side, can experience. We found this impacts
569 on value creation as clinical staff can experience additional pressures to meet patient
570 expectations which are often founded on receiving a holistic ‘experience’. This causes some
571 tension, as the clinical employees’ professional identities are at risk of being eroded as the
572 medical component of MT is subsumed into the larger ‘package’, causing some medical staff
573 to react assertively by reinforcing their medical credibility and undermining - or even
574 sabotaging - the hedonic aspects of value creation by diminishing it when interacting with
575 patients. This was evident from some medics we spoke with, who stated quite firmly: “*I*
576 *appreciate we want to have more foreign patients in our hospital. But I think doctor should do*
577 *the doctor job and tour person do his job. I believe the medical service is more important than*
578 *entertaining them here”* (Participant 35).

579 This is a phenomenon that is recognisable across other industrial contexts, including
580 social entrepreneurship, in which entrepreneurs experience a tension between mission-derived
581 activities and profit-based activities (Pache & Santos, 2013), and creative industries where
582 artists and managers navigate difficult relations (Bierne, 2012). In the MT context however,
583 we note that there was a division of labour in our case study hospital which compartmentalised
584 the leisure/hedonic aspects of packages and clinical care, leading to potentially inconsistent
585 approaches to value creation/customer experience (O’Cass & Sok, 2015; Taheri et al., 2017).

586

587 4.1.1 Quality provision

588

589 Medical and support staff were very aware of the importance of their care and support
590 on the overall perception of the hospital, supporting research focusing on medical service users
591 (Abd Manaf et al., 2015; Hall, 2017; Han & Hwang, 2013; Lovelock & Lovelock, 2018). Staff
592 also acknowledged the importance of reputation and accreditation on their attractiveness as a
593 destination of choice (Lunt & Carrera, 2011; Moghavvemi et al., 2017; Smith & Forgione,
594 2007): “*You know if we do our job properly with regards to whatever government asks us to*
595 *do, we will stay as a high ranked hospital which is good”* (Participant 19).

596 The importance of quality of provision on tourist's choice of this particular facility and
597 appraisal of the service offered (Fetscherin & Stephano, 2016) was recognised by management
598 and there were clear structures and systems in place to ensure that the level of care was
599 consistently high. In order to maintain accreditation incentives were developed to encourage
600 compliance. We found that, in the main, staff also showed understanding of the rules and also
601 the importance of transparency of systems and collaboration across departments. Many staff
602 expressed a personal pride in achieving international recognition, and there was a realisation
603 that this was an important means of attracting international patients, which in turn, secures the
604 future and prosperity of the hospital.

605 However, even whilst acknowledging the importance of the monitoring of quality of
606 provision on actual service offer to patients (Abd Manaf et al., 2017; Fetscherin & Stephano,
607 2016; Moghavvemi et al., 2017), some interviewees stressed how this service focus impacted
608 upon their day-to-day roles. Particular issues highlighted were the work involved in what were
609 regarded as extra administrative tasks and the time this took them away from their other more
610 patient-focused roles. Some interviewees felt particularly conflicted by what they felt to be an
611 increasingly controlling environment, with punitive measures enforced for those not following
612 the rules. Whilst they understood the rationale behind these measures they felt these were
613 overly-driven by the financial targets of the hospital and that these controls also had negative

614 impacts on the day to day working experiences of staff at the *hospital*: "You know there are
615 *always some fines involved if we do not follow them*" (Participant 37).

616

617 *4.1.2 Intensifying competition*

618

619 Our qualitative interviews surfaced some insights into the effects of competition on MT
620 providers. MT is seen as a potentially lucrative business proposition and interviewees talked
621 of the increasing local competition in this market. Providers reacted to local competitive
622 pressures by considering ways to provide enhanced value (Hall, 2017; Momeni et al., 2018).
623 They did this in a number of ways, including a focus on the quality of their service, extending
624 the variety of treatments on offer and focusing on the growing demand from the international
625 market.

626 Thus, the competitiveness of the neighbouring markets had a positive impact on value
627 creation (O’Cass & Sok, 2015; Taheri et al., 2017), as it led to the MT facility investing more
628 in-service delivery as a means of differentiating the value proposition. Furthermore, it caused
629 them to reflect critically on various aspects of practice, and they displayed an openness to
630 removing ineffective processes and replacing them with newer ways of doing things. However,
631 it was noted that competition in the local market had the potential to drive down prices, which
632 again led to a focus on differentiated, higher-value treatments.

633

634 *4.2 Quantitative analysis*

635

636 *4.2.1 Assessment of the measurement model*

637

638 Convergent validity of reflective constructs were assessed using composite reliability
639 (CR), Cronbach’s Alpha (α), factor loadings and average variance extracted (AVE). CR and α
640 indicated values above the mandatory thresholds of 0.7. The AVE values exceeded the
641 threshold of 0.5 for all constructs and factor loadings exceeded the recommended value of 0.6
642 (Hair et al., 2010) (see **Table 5**). We assessed discriminant validity with various methods.
643 Following Fornell and Larcker (1981) suggestion, the square root of the AVE (diagonal values)
644 of all constructs were larger than all other cross correlations in **Table 6**. The correlations among
645 all first-order reflective constructs were well below the 0.7 cut-off value in **Table 6**.

646

Table 5

647

Descriptive statistics, validity, reliability of the constructs.

Constructs	Items	Mean	SD	Skewness	Kurtosis	Loadings*	AVE	CR	α
MTI- Country Environment (D1)							0.596	0.870	0.822
	Stable exchange rate	4.89	1.182	-1.021	-0.858	0.687			
	Low corruption	4.03	1.819	-1.218	-0.912	0.665			
	Cultural similarity	4.34	2.125	1.327	-1.235	0.789			
	Overall positive country image	4.92	1.928	1.643	-0.697	0.707			
	Language similarity	4.77	1.792	1.626	-0.693	0.764			
	Safe to travel to country	4.77	1.111	-1.077	-0.811	0.776			
	Stable economy	4.56	1.019	-1.569	-0.936	0.780			
MTI- Tourism Destination (D2)							0.518	0.843	0.767
	Popular tourist destination	4.83	1.647	1.027	-0.168	0.769			
	Exotic tourist destination	4.12	1.259	1.003	0.463	0.740			
	Weather conditions	4.17	1.642	2.311	-3.449	0.690			
	Attractiveness of the country as a tourist destination	5.06	1.258	-2.003	3.411	0.701			
	Many cultural and natural attractions	4.09	1.551	-1.339	-0.656	0.695			
MTI- Medical Tourism Costs (D3)							0.577	0.815	0.711
	Low cost of treatment	4.58	1.171	-2.078	-4.069	0.692			
	Lower healthcare costs	4.47	1.601	1.381	-0.994	0.669			
	Low cost of accommodation	4.08	1.364	2.159	-1.019	0.767			
	Low costs to travel	5.93	0.961	2.171	3.811	0.811			
	Affordability of airfares	5.91	0.801	1.370	2.721	0.756			
MTI- Facility and Services (D4)							0.507	0.889	0.864
	Doctor's training	4.08	2.076	-1.120	-1.300	0.616			
	Doctor's expertise	4.81	2.210	-1.027	-1.415	0.601			
	High healthcare quality indicators (e.g., low infection rate)	4.49	1.987	-1.257	-4.206	0.638			
	Reputation of doctors	4.91	1.918	-2.011	-2.981	0.696			
	High quality standards	4.50	2.032	1.323	-1.036	0.692			

	High quality of care	4.72	2.069	1.110	0.071	0.663			
	State-of-the-art medical equipment	4.76	2.197	1.082	-1.469	0.716			
	Quality in treatments and materials	4.13	2.188	-3.266	-3.465	0.642			
	Accreditation of the medical facility	4.85	1.774	-1.449	-1.040	0.615			
	Reputation of the hospital/facility	4.89	1.802	-1.334	-0.977	0.723			
	Country medical reputation	4.91	1.907	-3.431	-0.991	0.750			
	International certified doctors	4.72	1.483	-1.302	0.153	0.669			
	Internationally certified staff	4.20	1.893	-4.115	-1.208	0.669			
	International educated doctors	4.69	1.419	-1.191	-1.050	0.678			
	Friendliness of staff and doctors	5.77	1.521	-4.410	-1.037	0.609			
	Family recommendation of doctors	4.92	1.395	1.259	0.718	0.648			
	Family/friend recommendation of the hospital/facility	4.82	1.891	4.287	-2.929	0.659			
Medical Staff Quality							0.526	0.895	0.875
	The nurses allowed me to ask many questions, enough to clarify everything	4.89	1.182	-1.029	-0.858	0.719			
	The nurses adequately explained my condition, examination results and medical process	4.03	1.819	-2.218	-0.912	0.719			
	There was ease of assembling and transmitting of medical record/information	4.34	2.125	4.327	-1.235	0.606			
	Medical staff were polite and friendly	4.92	1.928	2.643	-0.697	0.676			
	The process for setting up the medical procedure appointment was simple and easy	4.77	1.792	1.626	-0.693	0.689			
	The nurses paid enough attention to my concerns in deciding on a medical procedure	4.58	1.171	-1.078	-1.069	0.641			
	The hospital has adequate grievance channel for patients	4.47	1.603	1.381	-0.994	0.731			
	The hospital has acceptable protection against medical malpractice and liability	4.08	1.311	1.159	-1.019	0.621			
	The medical staff have good communication skills	4.93	0.968	1.471	2.811	0.727			
	Arrangement for language interpretation service is provided	4.91	2.823	4.370	2.721	0.747			
	Availability of medical staff and nurses who can speak my language	4.40	1.951	-3.074	-1.164	0.766			

Supporting Quality	Services	Short waiting time for the medical examination from the nurses and medical staff	4.57	1.766	-2.261	-0.782	0.744	0.534	0.872	0.824
Tourism Involvement		The hospital amenities (cafeteria and public telephone) were conveniently located	4.78	2.076	-3.120	-1.300	0.695	0.575	0.778	0.744
		Hospital care facilities (laboratory and doctors' office) were easy to find	4.81	2.210	-3.027	-1.415	0.684			
		The hospital's attention to patient s' privacy, confidentiality and disclosure is good	4.11	1.695	-2.257	-1.206	0.803			
		The hospital has state-of-the-art facilities and equipment	4.91	1.918	-1.011	-0.981	0.802			
		The hospital provides free Internet access	4.77	2.076	3.720	0.987	0.762			
		The payment procedure was quick and simple	4.81	2.210	1.323	-1.036	0.717			
Destination Distinction		There are a variety activity for you to participate in	4.93	2.032	4.323	-1.036	0.605	0.576	0.844	0.758
		The activities that you can participate in are interesting	4.72	2.069	1.110	0.071	0.904			
		You can freely participate in various tourist activities	4.76	2.197	1.082	-1.469	0.904			
Perceived Value		This city is unique	4.13	2.188	-3.266	-1.465	0.692	0.547	0.784	0.703
		This city has distinctive features that are not offered anywhere else	4.85	1.774	-1.449	-1.040	0.769			
		This city offers something different than the norm	4.89	1.802	-1.334	-0.977	0.783			
		This city is the only one of its kind	4.91	1.907	-2.431	-0.991	0.787			
		The medical treatment service and city offerings in this hospital is worth the price I paid	4.58	1.961	0.071	2.811	0.772			
		I think this hospital and city provide a good deal and service	4.43	1.801	0.370	2.721	0.743			

WoM	I think this hospital and city provide me great value as compared to other medical treatment/healthcare places/clinics and cities	4.89	1.002	1.408	2.073	0.702			
							0.530	0.817	0.714
	I will say positive things about this hospital and City to other people	4.69	1.951	-1.074	-1.164	0.618			
	I will recommend this hospital and City to someone who seeks my advice	4.51	1.766	-1.261	-0.780	0.801			
	I will encourage friends and relatives to stay at this hospital and City	4.87	1.861	-1.581	-1.970	0.773			
	I'm likely to spread positive word-of-mouth about this hospital and City	4.91	1.694	-1.387	-1.738	0.706			

648 Note: *t*-values for the item loadings to two-tailed test: $t > 2.57$ at $*p < 0.01$.
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Table 6
Discriminant validity.

	1	2	3	4	5	6	7	8	9	10	11
(1) MTI	n/a										
(2) WoM	0.04	0.72									
	7	0									
(3) Country	0.51	0.04	0.77								
Environmen	9	9	2								
t											
(4)	0.04	0.26	0.00	0.75							
Destination	3	7	3	8							
Distinction											
(5) Facility	0.61	0.04	0.27	0.06	0.71						
and Services	1	8	5	4	2						
(6) Tourism	0.05	0.39	0.01	0.35	0.06	0.75					
Involvement	1	6	0	6	5	8					
(7) Medical	0.01	0.00	0.02	0.20	0.00	0.21	0.72				
Staff	0	1	7	8	3	4	5				
Quality											
(8) Medical	0.64	0.00	0.29	0.00	0.56	0.03	0.03	0.75			
Tourism	3	9	9	2	5	6	5	9			
Costs											
(9)	0.05	0.31	0.00	0.61	0.06	0.24	0.25	0.00	0.73		
Perceived	3	6	9	0	6	8	4	7	9		
Value											
(10)	0.00	0.00	0.02	0.28	0.00	0.31	0.61	0.03	0.31	0.73	
Supporting	5	6	8	8	6	5	8	6	6	0	
Service											
(11)	0.62	0.02	0.26	0.01	0.53	0.00	0.02	0.46	0.07	0.02	0.75
Tourism	4	2	8	8	3	9	6	4	5	6	8
Destination											

652 Note: AVE square value of MTI construct is absent as MTI was specified as a higher-order model, with
653 AVEs only relevant to its 4 dimensions. Values on the bolded diagonal are square root of the AVE.

654
655 Henseler, Ringle, and Sarstedt (2015) also criticised Fornell and Larker (1981) criteria
656 by suggesting alternative approach of the heterotrait-monotrait (HTMT) ratio of correlations.
657 If the HTMT value is lower than 0.85, discriminant validity should be documented between
658 constructs. In our study, HTMT values of the first-order constructs surpassed HTMT 0.85
659 (**Table 7**) (Henseler et al., 2015). Thus, the reflective constructs have adequate convergent and
660 discriminant validity.

661
662

Table 7
HTMT results.

	1	2	3	4	5	6	7	8	9	10	11
(1) MTI											
(2) WoM	0.056										
(3) Country	0.679	0.070									
Environment											
(4)	0.063	0.338	0.003								
Destination											
Distinction											

(5) Facility and Services	0.016	0.047	0.336	0.104						
(6) Tourism Involvement	0.104	0.588	0.044	0.547	0.136					
(7) Medical Staff Quality	0.027	0.041	0.026	0.230	0.068	0.347				
(8) Medical Tourism Costs	0.706	0.019	0.402	0.002	0.703	0.065	0.061			
(9) Perceived Value	0.096	0.436	0.004	0.735	0.133	0.436	0.321	0.010		
(10) Supporting Service	0.031	0.000	0.033	0.366	0.065	0.543	0.684	0.044	0.455	
(11) Tourism Destination	0.743	0.026	0.331	0.015	0.640	0.010	0.040	0.643	0.116	0.035

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Following Becker et al. (2012) recommendation, we applied formative-formative hierarchical component model. For the MTI second-order construct, we assessed convergent validity, multicollinearity, external validity and nomological validity (Hair et al., 2017). Four first-order reflective dimensions of MTI had CR, α , AVE values above the required threshold values. Thus, each dimension demonstrated convergent validity. We checked multicollinearity among the indicators (Fetscherin & Stephano, 2016) by calculating the variance inflation factor (VIF) and the tolerance test of multicollinearity. Multi-collinearity was assessed using variance inflation factors (VIF) for the 4 sub-scales comprising the second-order MTI construct and the significance of outer weights (**Table 8**). The results are acceptable as VIFs for all four comprising the second-order construct are <3 (Hair et al., 2017). The tolerance statistics all well above 0.33 (ranging from 0.427 to 0.751), thus we can safely conclude that there is no collinearity within our data. Furthermore, we tested the external validity by calculating whether each dimension significantly correlated with a ‘global item’ that recaps the spirit of the MTI (i.e., meta-analytic approach) (Taheri, Jafari, & O’Gorman, 2014; Wanous & Reichers, 1999). In doing so, we used an item in our survey based on the definition of MTI: ‘In my opinion, a medical tourism destination should provide overall country environment, healthcare costs and tourism attractiveness, and quality of medical facilities and services’. As shown in **Table 8**, all four dimensions significantly correlate with the global item. Thus, external validity was established. Finally, we tested nomological validity in our PLS-SEM to assure if our MTI construct acts as expected (Bagozzi, 1980; Fetscherin & Stephano, 2016; Hair et al., 2017; Hair et al., 2010). **Table 8** represents weights of the first order constructs on the second order construct. The weights illustrate items with greater effect in the explanation of each construct. All related path relationships are significant, which supports the nomological validity of MTI construct.

Table 8

Weights of the first order constructs on the second order construct.

MTI-Dimension	Spearman’s rank correlation coefficient	Weight*
Country Environment	0.242*	0.719*

Tourism Destination	0.341*	0.724*
Medical Tourism Costs	0.318*	0.743*
Facility and Services	0.338*	0.911*

693 Note: t -values for the item loadings to two-tailed test: $t > 2.57$ at $*p < 0.01$.

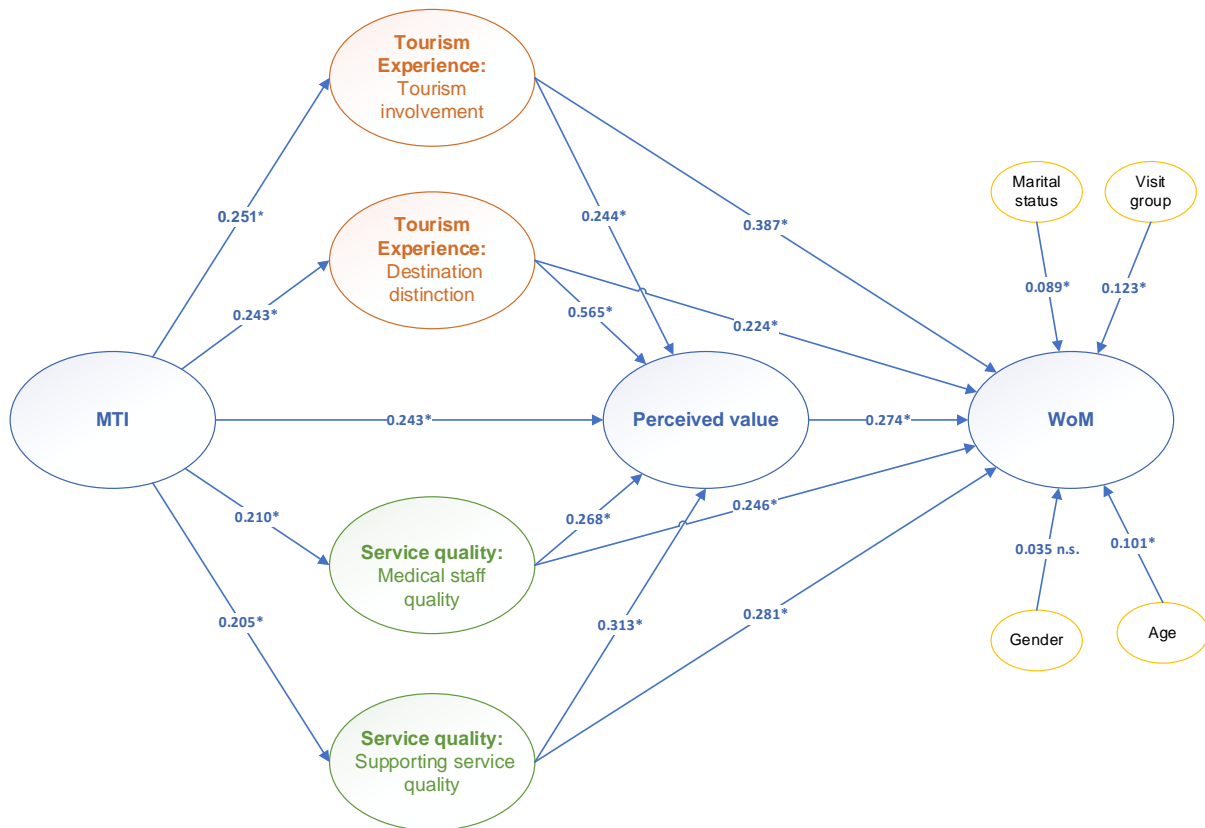
694

695 **4.2.2 Assessment of the structural model**

696

697 For the structural model, the non-parametric bootstrapping technique was tested with
698 785 cases, 5000 subsamples. Stone-Geisser's Q^2 value tested the criterion of predictive
699 relevance (Hair et al., 2017). The Q^2 value was achieved by using the blindfolding procedure.
700 For this study, we employed cross-validated redundancy procedure to assess Q^2 . A Q^2 value
701 greater than 0 indicates the model has predictive relevance. Q^2 values are above this threshold
702 in our study. We also used SRMR (standardised root mean square residual) as a fit indicator
703 (Henseler et al., 2014). Our SRMR value is 0.037 which is less than recommended value of
704 0.08. We also tested Cohen's effect sizes (f^2). Cohen's effect sizes (f^2) signifies 0.01 for small,
705 0.06 for medium, and 0.14 for large effects within a structural equation modelling approach.
706 (Khalilzadeh & Tasci, 2017). The model explains 18% of tourism involvement, 22% of
707 destination distinction, 33% of medical staff quality, 17% supporting service quality, 39% of
708 perceived value and 34% of WoM. As shown in **Fig 3**, all path relationships were supported.
709 In practice, we connected the control variables to WoM. In terms of the control variables, age,
710 visit group and marital status found to be significantly connected to participants WoM. Gender
711 has no significant effect on the WoM.

712



Note: t -values for the item loadings to two-tailed test: $t > 2.57$ at $*p < 0.01$; n.s. = non-significant.

713

714 **Fig. 3.** Results of structural model.

715

716 4.2.3 Post-hoc analysis of the indirect effects

717

718 The findings proposed the potential existence of mediating relationships for the study
719 (i.e., post-hoc analysis of the indirect effects). Following Williams and MacKinnon (2008) and
720 Perez-Vega, Taheri, Farrington, and O’Gorman (2018) recommendations, bootstrapping
721 analysis for the significance of the indirect effects considering the *t*-values as well as the
722 confidence interval (CI) were used. Following **Table 9**, the results indicate that MTI indirectly
723 influences perceived value through tourism involvement (95% CI = [0.103, 0.147]), destination
724 distinction (95% CI = [0.202, 0.256]), medical staff quality (95% CI = [0.123, 0.157]) and
725 supporting service quality (95% CI = [0.250, 0.293]). Since the direct effect were significant,
726 the results reveal that involvement, destination distinction, medical staff quality and supporting
727 service quality partially mediate the influence of MTI on perceived value. Similarly, results
728 reveal indirect effect of tourism involvement (95% CI = [0.289, 0.346]), destination distinction
729 (95% CI = [0.266, 0.298]), medical staff quality (95% CI = [0.217, 0.1247]) and supporting
730 service quality (95% CI = [0.248, 0.284]) through perceived value on WoM were significant.
731 Since the direct effects were significant, the results indicate that perceived value partially
732 mediate the influence of tourism involvement, destination distinction, medical staff quality and
733 supporting service quality on WoM (see **Table 9**).

734

735 **Table 9**

736 Estimates of indirect effects.

Indirect path	Indirect effect*	Low CI	High CI
MTI → Tourism Involvement → Perceived value	0.123	0.103	0.147
MTI → Destination Distinction → Perceived value	0.238	0.202	0.256
MTI → Medical Staff Quality → Perceived value	0.139	0.123	0.157
MTI → Supporting Service Quality → Perceived value	0.278	0.250	0.293
Tourism Involvement → Perceived value → WoM	0.321	0.289	0.346
Destination Distinction → Perceived value → WoM	0.289	0.266	0.298
Medical Staff Quality → Perceived value → WoM	0.233	0.217	0.247
Supporting service Quality → Perceived value → WoM	0.268	0.248	0.284

737 Note: *t*-values for the item loadings to two-tailed test: $t > 2.57$ at $*p < 0.01$.

738

739 5. Conclusion and implications

740

741 5.1 Theoretical contributions

742

743 The paper has examined, using mixed methods, two core questions: 1) How is value
744 created through service delivery within a MT hospital and what organisational factors influence
745 MT patient experience? and; 2) What effect do the expectations and experience of medical
746 tourism have on word of mouth referrals?

747 In answering these questions, our study makes a number of contributions to MT
748 research. First, our model integrates constructs relating to destination distinction, healthcare
749 provision and the perceived value of the treatment package. From our quantitative study, we
750 found MTI positively influences tourism involvement, destination distinction, medical staff
751 quality, supporting service quality and perceived value, aligning with previous studies by (e.g.,
752 Abd Manaf et al., 2015; Gursoy & Gavcar, 2003; Han & Hyuan, 2012; Lee, 2010; Qu et al,

201; Kim & Han, 2008; Prayag & Ryan 2012; Viladrich & Baron-Faust, 2014). Tourism involvement, destination distinction, medical staff quality and supporting service quality positively influence perceived value which further supports previous studies (e.g., Abd Manaf et al., 2015; Kim & Han, 2008; Lee, 2010; Lovelock & Lovelock, 2018; Prayag & Ryan, 2012; Qu et al., 2011). Finally, tourism involvement, destination distinction, medical staff quality, supporting service quality and perceive value positively impact on WoM, supporting previous studies (e.g., Abd Manaf et al., 2015; Fetscherin & Stephano, 2016; Gursoy & Gavcar, 2003; Lu et al., 2015; Prayag & Ryan, 2012; Pike & Ryan, 2004). The results also provide several indirect effects between constructs (**Table 9**) which we propose require further investigation. Thus, we found that aspects of service experience (around medical treatment) and destination, positively influence perceived value and ultimately result in the intention to recommend and refer the MT provider. We believe the results are robust since we controlled for control variables in our study.

Medical tourism is a significant economic trend. The market for medical tourism is expanding, and many developing countries are capitalising on both their distinct medical competences and cultural assets to attract foreign visitors to their hospitals. A recent comprehensive analysis of 392 MT articles concluded that scholars should shift attention towards “economic and marketing issues” to advance the research field (Chuang et al., 2014, p. 57). Accordingly, we use the case of a MT hospital in Iran to explore the antecedents of WoM and the perceived value of treatment packages. WoM is critical for MT providers as it has been identified by scholars as the most significant marketing channel for prospective patients (Lee, 2010; Yeoh et al., 2013). We diverge from previous MT studies however, by examining the drivers rather than consequences of WoM (e.g., Abubakar, 2016) and in doing so advance a detailed theoretical model of the cognitive factors influencing WoM referrals.

Our service-delivery focus offers an important new perspective on the organisational-level dynamics that are shaping WoM in a MT context. The role of professional identity and the increasing commercialisation of medical care has been overlooked as a research topic, with only a small body of literature examining this key facet of MT (Skountridaki, 2017). Recognising that patient evaluations of their experience at a MT facility can be formed by interactions with *any* member of staff (from porter through to surgeon), we draw on empirical materials from all job families in the hospital to understand some of the positive and negative factors influencing value creation (O’Cass & Sok, 2015; Taheri et al., 2017). Interestingly, while senior medics worry about their professional identity (i.e., not being viewed as ‘entertainers’), administrative and support staff were increasingly consumed by pressures relating to accreditation and ranking. These findings offer an interesting counterpoint to recent research from a patient perspective (Lovelock & Lovelock, 2018) which stresses that medical tourists have often high expectations of a leisure component, which we suggest could be undermined by clinical staff who are not sufficiently ‘on board.’

Research has highlighted the importance of WoM for MT service providers, yet the key antecedents in a medical tourism context are, thus far, less understood. MT providers must deliver service provision to patients who have dual expectations related to their medical treatment and also their wider tourism experience (Yu & Ko, 2012). In this research, we find that tourism and service experience are both positively related to WoM referrals and that perceptions of value are determined by both. We conclude by highlighting the criticality of perceptions of service quality on WoM directly and also mediated through perceived value. Our findings highlight the salience of supporting service quality to the overall service experience of MT patients. Thus, medical service providers need to pay attention to the ‘softer’ elements of service delivery such as ease of payments, free internet provision and hospital amenities as well as the actual medical care.

802 We also offer a novel perspective on MT by soliciting data from both consumers of
803 MT services and those who participate in the delivery of MT services (ranging from doctors to
804 hospital managers). Extant MT research has typically focussed on patient data alone (e.g., Yeoh
805 et al., 2013) and this has restricted understanding of the service dimension of MT. We therefore
806 offer a valuable insight into aspects of service delivery through our qualitative data by
807 unpacking how everyday service delivery tensions encountered by medics and support staff
808 may influence evaluations from MT patients. Our MT provider data for example, shows some
809 of the tensions faced within medical facilities by those who have to provide medical care, while
810 also providing a tourism ‘experience.’ Rather than finding outright hostility, or resentment
811 towards the dual role, we found staff across different positions keen to try adapting to the
812 competitive situation, though this is not without challenges, as our data indicates.

813 We suggest future studies develop this perspective further to understand how those with
814 different roles might experience the demands of MT care differently, and how this leads to
815 variances in how they interact with patients and influence WoM.

816 *5.2 Practical Implications*

817 Our findings provide some important implications for practitioners too. Specifically,
818 we confirm the importance of destination and medical care on perceived value (and ultimately,
819 likelihood of the patient to refer). As past literature underlines the importance of WoM for
820 generating medical tourism business (Abubakar, 2016), we emphasise the need for hospital
821 managers to consider both aspects of service delivery proportionately. This may entail MT
822 providers working to extend their influence over external destination factors that may presently
823 be beyond their control. For example, we note successful instances of retail and tourism
824 businesses working together to fund business or tourism improvement districts that shape
825 broader aspects of destination experience (e.g., language support for workers at key sites of
826 interest, public realm upgrading, cleanliness and transport improvement). Second, we find that
827 MT providers use other local hospitals as competitive benchmarks, and a result there is a trend
828 towards replicating each other's strategies (which mostly involves adding more services and
829 expanding). We suggest an alternative strategy for MT providers in crowded local markets is
830 to identify differentiating high-value specialisms that will draw patients from non-traditional
831 markets. Existing strategies risk dilution of capabilities and a race to the bottom in terms of
832 price, which undermines the sustainability of the MT sector in Iran. Third, the quantitative
833 results confirmed the direct and/or indirect effects of MTI, tourism involvement, destination
834 distinction, medical staff quality, supporting service quality, perceived value on medical
835 tourists’ WoM. Understanding tourism experience and medical service quality may prove
836 critical to producing a sustainable medical tourism economy in the developing Iranian context.
837 To provide a high-quality medical tourism, local authorities, hospital staff and tourism planners
838 should invest both time and money in increasing level of tourism experience (i.e., tourism
839 involvement and destination distinction) and medical service quality (i.e., medical staff quality
840 and supporting service quality).

841 Moreover, by carefully crafting marketing communications, service trails and creating
842 awareness through targeted campaigns in different places with the aim of motivating WoM
843 communication (e.g., billboards in international airports, instant photo sharing about different
844 medical and tourism experiences in social media platforms), the tourism experience and
845 medical service quality elements can be promoted to different target audiences and segments.

846 *5.3 Limitations and future research agenda*

851 While we believe our model can be applied to a broad range of contexts, we recognise
852 that there are distinct socio-cultural aspects to our case that necessarily bound our theory.
853 Similarly, our data does not consider the nature of treatment as a potentially significant variable
854 in how WoM is configured. Studies have begun to unpick the differences is purely cosmetic
855 treatments and those that are more essential to long-term health (Chuang et al., 2014) and we
856 recommend this warrants further examination.

857 Additionally, we recognise that few scholars (e.g., Lovelock & Lovelock, 2018) have
858 considered how those *accompanying* patients on trips may shape WoM (89.4% of our survey
859 participants had a friend or family member accompanying them). The interpersonal dynamics
860 between the patient and these additional travellers may yield further insights into WoM. For
861 example, as one may imagine emotions such as guilt at travelling to a destination with high
862 medical staff quality but lower tourism involvement (and hence a worse experience for travel
863 companions) skewing WoM. Thus, we advocate a move from studying the patient as the focal
864 unit of analysis in MT (Fetscherin & Stephano, 2016) and encourage a move towards a holistic
865 ‘customer decision-making unit’ that involves patients *and* travel companions. This, we
866 conclude, would more accurately reflect the cognitive work associated with WoM and the
867 reality of MT service consumption.

868 Finally, Momeni et al. (2018) and Penney, Snyder, Crooks, and Johnston (2011) note
869 the potentially negative role of ‘brokers’ in medical tourism transactions. Brokers act as
870 intermediaries between MT hospitals and patients, and, as such, may influence WoM referral
871 where patients do not distinguish between different actors in the MT value chain. While our
872 empirical sample focussed solely on direct employees of the MT facility, future research should
873 therefore incorporate other (often indirect) actors in the MT value chain (for example brokers,
874 airlines, taxi drivers) who contribute to the overall WoM recommendation. This could extend
875 recent research that has examined how pre-consumption experiences influence perceived value
876 of products and services (Jiang, Luk, & Cardinali, 2018).

877

878 **References**

879

- 880 Abubakar, A. M., & Ilkan, M. (2016). Impact of online WoM on destination trust and intention
881 to travel: A medical tourism perspective. *Journal of Destination Marketing &*
882 *Management*, 5(3), 192-201.
- 883 Alcañiz, E. B., García, I. S., & Blas, S. S. (2009). The functional-psychological continuum in
884 the cognitive image of a destination: A confirmatory analysis. *Tourism Management*,
885 30(5), 715-723.
- 886 Alves, S., Abrantes, J. L., Antunes, M. J., Seabra, C., & Herstein, R. (2016). WOM antecedents
887 in backpacker travellers. *Journal of Business Research*, 69(5), 1851-1856.
- 888 Anderson, E. W. (1998). Customer satisfaction and word of mouth. *Journal of Service*
889 *Research*, 1(1), 5-17.
- 890 Armstrong, J.S, & Overton, T.S. (1977) Estimating nonresponse bias in mail surveys. *Journal*
891 *of Marketing Research* 14: 396-402.
- 892 Abd Manaf, N. H., Hussin, H., Kassim, P. N. J., Alavi, R., & Dahari, Z. (2015). Medical
893 tourism service quality: finally some empirical findings. *Total Quality Management &*
894 *Business Excellence*, 26(9), 1017-1028.
- 895 Abd Manaf, N. H., Maulan, S., Hussin, H., Jahn Kassim, P. N., & Alavi, R. (2017). Service
896 quality, value, satisfaction and future intention in medical tourism. *Journal of Tourism,*
897 *Hospitality & Culinary Arts*, 9(3), 1-12.
- 898 AMAR. (2016). Statistical Centre of Iran Retrieved Dec, 2016, from
899 [https://www.amar.org.ir/english/Statistics-by-Topic/Education-and-](https://www.amar.org.ir/english/Statistics-by-Topic/Education-and-Research#2217482-meta-data)
900 [Research#2217482-meta-data](https://www.amar.org.ir/english/Statistics-by-Topic/Education-and-Research#2217482-meta-data)
- 901 Azadi, F., Maleki, M., Tabibi, S. J., & Azmal, M. (2012). A medical tourist perception of
902 Iranian hospital quality: Limited employee foreign language skills negatively impact
903 communication. *International Journal of Hospital Research*, 1(2), 85-90.
- 904 Bagozzi, R.P. (1980). *Causal models in marketing*. Wiley, New York.
- 905 Alexander, M., MacLaren, A., O’Gorman, K., & Taheri, B. (2012). “He just didn’t seem to
906 understand the banter”: Bullying or simply establishing social cohesion? *Tourism*
907 *Management*, 33(5), 1245-1255.
- 908 Becker, J.-M., Klein, K., & Wetzels, M. (2012). Hierarchical latent variable models in PLS-
909 SEM: Guidelines for using reflective-formative type models. *Long Range Planning*, 45,
910 359-394.
- 911 Beerli A., & Martín J. D. (2004). Factors influencing destination image. *Annals of Tourism*
912 *Research*, 31(3), 657–681.
- 913 Berger, J. (2014). Word of mouth and interpersonal communication: A review and directions
914 for future research. *Journal of Consumer Psychology*, 24(4), 586-607.
- 915 Berkowitz, E. N., & Flexner, W. (1980). The market for health services: is there a non-
916 traditional consumer? *Journal of Health Care Marketing*, 1(1).
- 917 Bierne, M. (2012). Creative tension? Negotiating the space between the arts and management.
918 *Journal of Arts & Communities*, 4(3), 149-160.
- 919 Broderick, A. J., & Mueller, R. D. (1999). A theoretical and empirical exegesis of the consumer
920 involvement construct: The psychology of the food shopper. *Journal of Marketing*
921 *Theory and Practice*, 7(4), 97-108.
- 922 Brocato, E. D., Baker, J., & Voorhees, C. M. (2015). Creating consumer attachment to retail
923 service firms through sense of place. *Journal of the Academy of Marketing*
924 *Science*, 43(2), 200-220.
- 925 Brotman, B. A. (2010). Medical tourism private hospitals: Focus India. *Journal of Health*
926 *Care Finance*, 37(1), 45-50.

- 927 Brown, T. J., Barry, T. E., Dacin, P. A., & Gunst, R. F. (2005). Spreading the word:
 928 Investigating antecedents of consumers' positive word-of-mouth intentions and
 929 behaviors in a retailing context. *Journal of the Academy of Marketing Science*, 33(2),
 930 123-138.
- 931 Buttle, F. A. (1998). Word of mouth: understanding and managing referral marketing. *Journal*
 932 *of Strategic Marketing*, 6(3), 241-254.
- 933 Carroll, B. A., & Ahuvia, A. C. (2006). Some antecedents and outcomes of brand love.
 934 *Marketing Letters*, 17(2), 79-89.
- 935 Chin, W. W. (2010). How to write up and report PLS analyses. In V. Esposito Vinzi, W. W. Chin,
 936 J. Henseler, & H. Wang (Eds.), *Handbook of partial least squares: Concepts, methods*
 937 *and application* (pp. 645–689).
- 938 Chi, C.G.Q. & Qu, H. (2008). Examining the structural relationships of destination image,
 939 tourist satisfaction and destination loyalty: an integrated approach. *Tourism*
 940 *Management*, 29 (4), pp. 624-636.
- 941 Chuang, T. C., Liu, J. S., Lu, L. Y., & Lee, Y. (2014). The main paths of medical tourism:
 942 From transplantation to beautification. *Tourism Management*, 45, 49-58.
- 943 Creswell, J.W., & Creswell, J.D. (2018). *Research Design: Qualitative, Quantitative, and*
 944 *Mixed Methods Approaches*, Sage, USA.
- 945 Crompton, J. L. (1979). An assessment of the image of Mexico as a vacation destination and
 946 the influence of geographical location upon that image. *Journal of Travel Research*,
 947 17(4), 18-23.
- 948 Currás-Pérez, R., Bigné-Alcañiz, E. & Alvarado-Herrera, A. (2009). The role of self-
 949 definitional principles in consumer identification with a socially responsible company.
 950 *Journal of Business Ethics*, 89 (4) (2009), 547-564.
- 951 Cohen, E. C. E. (2008). Medical tourism in Thailand. *AU-GSB e-journal*, 1(1).
- 952 Connell, J. (2006). Medical tourism: Sea, sun, sand and... surgery. *Tourism*
 953 *Management*, 27(6), 1093-1100.
- 954 Connell, J. (2013). Contemporary medical tourism: Conceptualisation, culture and
 955 commodification. *Tourism Management*, 34, 1-13.
- 956 Crooks, V. A., Turner, L., Snyder, J., Johnston, R., & Kingsbury, P. (2011). Promoting medical
 957 tourism to India: Messages, images, and the marketing of international patient
 958 travel. *Social Science & Medicine*, 72(5), 726-732.
- 959 Crompton, J. L. (1979). An Assessment of the Image of Mexico as a Vacation Destination and
 960 the Influence of Geographical Location upon the Image. *Journal of Travel Research*
 961 18(4):18–23
- 962 Crompton, J. (1992). Structure of vacation destination choice sets. *Annals of Tourism Research*,
 963 19(3), 420-434.
- 964 de la Hoz-Correa, A., Muñoz-Leiva, F., & Bakucz, M. (2018). Past themes and future trends
 965 in medical tourism research: A co-word analysis. *Tourism Management*, 65, 200-211.
- 966 Debata, B. R., Patnaik, B., Mahapatra, S. S., & Sree, K. (2015). Interrelations of service quality
 967 and service loyalty dimensions in medical tourism: a structural equation modelling
 968 approach. *Benchmarking: An International Journal*, 22(1), 18-55.
- 969 De Matos, C. A., & Rossi, C. A. V. (2008). Word-of-mouth communications in marketing: a
 970 meta-analytic review of the antecedents and moderators. *Journal of the Academy of*
 971 *Marketing Science*, 36(4), 578-596.
- 972 do Valle, P. O., & Assaker, G. (2016). Using partial least squares structural equation modeling
 973 in tourism research: A review of past research and recommendations for future
 974 applications. *Journal of Travel Research*, 55(6), 695-708.
- 975 Easterby-Smith, M., Thorpe, R., & Lowe, A. (2002). *Management Research: An Introduction*
 976 (2nd ed.). Sage Publications, London.

- 977 Eisenhardt, K. M. (1989). Making fast strategic decisions in high-velocity
 978 environments. *Academy of Management Journal*, 32(3), 543-576.
- 979 Fernandes, T., & Fernandes, F. (2018). Sharing dissatisfaction online: Analyzing the nature
 980 and predictors of hotel guests' negative reviews. *Journal of Hospitality Marketing &*
 981 *Management*, 27(2), 127-150.
- 982 Fetscherin, M., & Stephano, R. M. (2016). The medical tourism index: Scale development and
 983 validation. *Tourism Management*, 52, 539-556.
- 984 Fillieri, R. and McLeay, F. (2013). E-WoM and Accommodation: An Analysis of the Factors
 985 That Influence Travelers' Adoption of Information from Online Reviews. *Journal of*
 986 *Travel Research*, Vol. 53, No. 1, pp. 44-57.
- 987 Fornell, C., & Larcker, D. F. (1981). Evaluating structural equation models with unobservable
 988 variables and measurement error. *Journal of Marketing Research*, 39-50.
- 989 Funk, D. C., Ridinger, L. L., & Moorman, A. M. (2004). Exploring origins of involvement:
 990 Understanding the relationship between consumer motives and involvement with
 991 professional sport teams. *Leisure Sciences*, 26(1), 35-61.
- 992 Gannon, M.J., Baxter, I.W., Collinson, E., & Maxwell-Stuart, R. (2017). Travelling for Umrah:
 993 destination attributes, destination image, and post-travel intentions. *The Service*
 994 *Industries Journal*, 37(7-8), 448-465.
- 995 Gannon, M., Taheri, B., & Olya, H. (2019). Festival quality, self-connection and bragging.
 996 *Annals of Tourism Research*, 76, 239-252.
- 997 Gallarza, M. G., Saura, I. G., & García, H. C. (2002). Destination image: Towards a conceptual
 998 framework. *Annals of Tourism Research*, 29(1), 56-78.
- 999 Garcia-Altes, A. (2005). The development of health tourism services. *Annals of Tourism*
 1000 *Research*, 32(1), 262-266.
- 1001 Garson, D. (2016). *Partial Least Squares: Regression and Structural Equation Models*,
 1002 Statistical Associates Blue Book Series.
- 1003 Ghosh, T., & Mandal, S. (2019). Medical tourism experience: Conceptualization, scale
 1004 development, and validation. *Journal of Travel Research*, 58(8), 1288-1301.
- 1005 Gioia, D. A., Corley, K. G., & Hamilton, A. L. (2013). Seeking qualitative rigor in inductive
 1006 research notes on the Gioia methodology. *Organizational Research Methods*, 16(1),
 1007 15–31.
- 1008 Goodrich, J. N., & Goodrich, G. E. (1987). Health-care tourism—An exploratory study.
 1009 *Tourism Management*, 8(3), 217-222.
- 1010 Guiry, M., & Vequist, D. G. (2011). Traveling abroad for medical care: US medical tourists'
 1011 expectations and perceptions of service quality. *Health Marketing Quarterly*, 28(3),
 1012 253-269.
- 1013 Gursoy, D., & Gavcar, E. (2003). International leisure tourists' involvement profile. *Annals of*
 1014 *Tourism Research*, 30(4), 906-926.
- 1015 Hair, J. F. Black, W. C., Babin, B. J., & Anderson R. E., (2010) (2010) *Multivariate Data*
 1016 *Analysis: A Global Perspective*. Pearson, USA.
- 1017 Hair, J. F., Hult, T. M., Ringle, C. M., & Sarstedt, M. (2017) *A primer on Partial Least Squares*
 1018 *Structural Equation Modeling (PLS-SEM)*: Sage; Los Angeles, CA.
- 1019 Hall, M. (2017). *Medical Tourism: The ethics, regulation, and marketing of health mobility*.
 1020 Routledge Publication.
- 1021 Han, H. (2013) The healthcare hotel: Distinctive attributes for international medical travellers.
 1022 *Tourism Management*, 36: 257-268.
- 1023 Han, H., & Hyun, S. S. (2015). Customer retention in the medical tourism industry: Impact of
 1024 quality, satisfaction, trust, and price reasonableness. *Tourism Management*, 46, 20-29.

- 1025 Han, H., & Hwang, J. (2013). Multi-dimensions of the perceived benefits in a medical hotel
 1026 and their roles in international travellers' decision-making process. *International*
 1027 *Journal of Hospitality Management*, 35, 100-108.
- 1028 Han, H., Meng, B., & Kim, W. (2017). Bike-traveling as a growing phenomenon: Role of
 1029 attributes, value, satisfaction, desire, and gender in developing loyalty. *Tourism*
 1030 *Management*, 59, 91-103.
- 1031 Harrigan, P., Evers, U., Miles, M., & Daly, T. (2017). Customer engagement with tourism
 1032 social media brands. *Tourism Management*, 59, 597-609.
- 1033 Harrison-Walker, L. J. (2001). The measurement of word-of-mouth communication and an
 1034 investigation of service quality and customer commitment as potential antecedents.
 1035 *Journal of Service Research*, 4(1), 60-75.
- 1036 Hennig-Thurau, T., Gwinner, K. P., Walsh, G., & Gremler, D. D. (2004). Electronic word-of-
 1037 mouth via consumer-opinion platforms: what motivates consumers to articulate
 1038 themselves on the internet?. *Journal of Interactive Marketing*, 18(1), 38-52.
- 1039 Henseler, J., Dijkstra, T. K., Sarstedt, M., Ringle, C. M., Diamantopoulos, A., Straub, D. W.,
 1040 ... & Calantone, R. J. (2014). Common beliefs and reality about PLS: Comments on
 1041 Rönkkö and Evermann (2013). *Organizational Research Methods*, 17(2), 182-209.
- 1042 Henseler, J., Ringle, C. M., & Sarstedt, M. (2015). A new criterion for assessing discriminant
 1043 validity in variance-based structural equation modeling. *Journal of the Academy of*
 1044 *Marketing Science*, 43(1), 115-135.
- 1045 Henseler, J., Ringle, C. M., & Sinkovics, R. R. (2009) The use of partial least squares path
 1046 modeling in international marketing. *Advances in International Marketing*, 20: 277-
 1047 319.
- 1048 Heung, V. C., Kucukusta, D., & Song, H. (2011). Medical tourism development in Hong Kong:
 1049 An assessment of the barriers. *Tourism Management*, 32(5), 995-1005.
- 1050 Heung, V. C., Kucukusta, D., & Song, H. (2010). A conceptual model of medical tourism:
 1051 Implications for future research. *Journal of Travel & Tourism Marketing*, 27(3), 236-
 1052 251.
- 1053 Hudson, L. A., & Ozanne, J. L. (1988). Alternative ways of seeking knowledge in consumer
 1054 research. *Journal of Consumer Research*, 14(4), 508-521.
- 1055 Hunt, K. H. (1977). *CS/D – Overview and future research direction*, in *Conceptualization and*
 1056 *Measurement or Consumer Satisfaction and Dissatisfaction*, H. Keith Hunt (ed.).
 1057 Marketing Science Institution, Cambridge, Mass.
- 1058 Hwang, S. N., Lee, C., & Chen, H. J. (2005). The relationship among tourists' involvement,
 1059 place attachment and interpretation satisfaction in Taiwan's national parks. *Tourism*
 1060 *Management*, 26(2), 143-156.
- 1061 ICHTO (2018). "Handcraft and Tourism Organization" Tourism statistics of Iran. Heritage,
 1062 Iran Cultural. Available from: <https://www.mcth.ir/english>
- 1063 Jabbari, A., Ferdosi, M., Keyvanara, M., & Agharahimi, Z. (2013). Stakeholders' analysis of
 1064 the medical tourism industry: development strategies in Isfahan. *Journal of Education*
 1065 *and Health Promotion*, 2.
- 1066 Jafari, A., Taheri, B., & vom Lehn, D. (2013). Cultural consumption, interactive sociality, and
 1067 the museum. *Journal of Marketing Management*, 29(15-16), 1729-1752.
- 1068 Jiang, K., Luk, S. T. K., & Cardinali, S. (2018). The role of pre-consumption experience in
 1069 perceived value of retailer brands: Consumers' experience from emerging
 1070 markets. *Journal of Business Research*, 86, 374-385.
- 1071 Johnston, R., Crooks, V. A., & Snyder, J. (2012). "I didn't even know what I was looking for":
 1072 A qualitative study of the decision-making processes of Canadian medical
 1073 tourists. *Globalization and Health*, 8(1), 23.

- 1074 Kim, T. T., Kim, W. G., & Kim, H. B. (2009). The effects of perceived justice on recovery
1075 satisfaction, trust, word-of-mouth, and revisit intention in upscale hotels. *Tourism*
1076 *Management*, 30(1), 51-62.
- 1077 Khalilzadeh, J., & Tasci, A. D. (2017). Large sample size, significance level, and the effect
1078 size: Solutions to perils of using big data for academic research. *Tourism Management*,
1079 62, 89-96.
- 1080 Kim, W. & Han, H. (2008). Determinants of restaurant customers' loyalty intentions: a
1081 mediating effect of relationship quality. *Journal of Quality Assurance in Hospitality*
1082 *and Tourism*, 9 (3), 218-238
- 1083 Kreiner, G. E., Hollensbe, E. C., & Sheep, M. L. (2006). Where is the "me" among the "we"?
1084 Identity work and the search for optimal balance. *Academy of Management*
1085 *Journal*, 49(5), 1031-1057.
- 1086 Lee, C. G. (2010). Health care and tourism: Evidence from Singapore. *Tourism*
1087 *Management*, 31(4), 486-488.
- 1088 Lee, J., & Beeler, C. (2009). An investigation of predictors of satisfaction and future intention:
1089 links to motivation, involvement, and service quality in a local festival. *Event*
1090 *Management*, 13(1), 17-29.
- 1091 Lee, O. F., & Davis, T. R. (2005). International patients: A lucrative market for US hospitals.
1092 *Health Marketing Quarterly*, 22(1), 41-56.
- 1093 Lee, C., Hallak, R., & Sardeshmukh, S. R. (2016). Innovation, entrepreneurship, and restaurant
1094 performance: A higher-order structural model. *Tourism Management*, 53, 215-228.
- 1095 Liang, H., Saraf, N., Hu, Q., & Xue, Y. (2007). Assimilation of Enterprise Systems: The Effect
1096 of Institutional Pressures and The Mediating Role of Top Management. *MIS Quarterly*
1097 31: 59-87.
- 1098 Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage
1099 Publications, Inc.
- 1100 Litvin, S. W., Goldsmith, R. E., & Pan, B. (2008). Electronic word-of-mouth in hospitality and
1101 tourism management. *Tourism Management*, 29(3), 458-468.
- 1102 Lovelock, B., & Lovelock, K. (2018). "We had a ball... as long as you kept taking your
1103 painkillers" just how much tourism is there in medical tourism? Experiences of the
1104 patient tourist. *Tourism Management*, 69, 145-154.
- 1105 Lovelock, B., Lovelock, K., & Lyons, K. (2018). The impact of outbound medical (dental)
1106 tourism on the generating region: New Zealand dental professionals' perspectives.
1107 *Tourism Management*, 67, 399-410.
- 1108 Lu, H. Y., Wu, W. Y., & Chen, S. H. (2016). Influences on the perceived value of medical
1109 travel: the moderating roles of risk attitude, self-esteem and word-of-mouth. *Current*
1110 *Issues in Tourism*, 19(5), 477-491.
- 1111 Lu, L., Chi, C. G., & Liu, Y. (2015). Authenticity, involvement, and image: Evaluating tourist
1112 experiences at historic districts. *Tourism Management*, 50, 85-96.
- 1113 Lunt, N., & Carrera, P. (2011). Systematic review of web sites for prospective medical
1114 tourists. *Tourism Review*, 66(1/2), 57-67.
- 1115 Mangold, G. W., & Babakus, E. (1991). Service quality: The front-stage vs. the back-stage
1116 perspective. *Journal of Services Marketing*, 5(4), 59-70.
- 1117 Manaf, N. H. A., Hussin, H., Kassim, P. N. J., Alavi, R., & Dahari, Z. (2015). Medical tourism
1118 service quality: finally some empirical findings. *Total Quality Management & Business*
1119 *Excellence*, 26(9-10), 1017-1028.
- 1120 Market Analysis Report (2020). Medical Tourism Market Size, Share & Trends Analysis
1121 Report By Country (Thailand, India, Costa Rica, Mexico, Malaysia, Singapore, Brazil,
1122 Colombia, Turkey, Taiwan, South Korea, Spain, Czech Republic), And Segment
1123 Forecasts, 2020 – 2027.

- 1124 Mathijsen, A. (2019). Home, sweet home? Understanding diasporic medical tourism
 1125 behaviour. Exploratory research of Polish immigrants in Belgium. *Tourism*
 1126 *Management*, 72, 373-385.
- 1127 Mardia, K. V. (1970). Measures of multivariate skewness and kurtosis with
 1128 applications. *Biometrika*, 57(3), 519-530.
- 1129 Mattoo, A., & Rathindran, R. (2006). How Health Insurance Inhibits Trade In Health Care.
 1130 *Health Affairs*, 25, no.2 (2006):358-368. Available from
 1131 <http://content.healthaffairs.org/content/25/2/358.full.html>
- 1132 Maxham III, J. G., & Netemeyer, R. G. (2002). A longitudinal study of complaining customers'
 1133 evaluations of multiple service failures and recovery efforts. *Journal of*
 1134 *Marketing*, 66(4), 57-71.
- 1135 Miles, M. B., & Huberman, M. A. (1994). *Qualitative data analysis - an expanded sourcebook*.
 1136 Sage Publications, Newbury Park.
- 1137 Min, H., Park, J. & Kim, H.J. (2016). Common method bias in hospitality research: A critical
 1138 review of literature and an empirical study. *International Journal of Hospitality*
 1139 *Management*, 56, 126-135.
- 1140 Moghavvemi, S., Ormond, M., Musa, G., Isa, C. R. M., Thirumoorthi, T., Mustapha, M. Z. B.,
 1141 & Chandy, J. J. C. (2017). Connecting with prospective medical tourists online: A
 1142 cross-sectional analysis of private hospital websites promoting medical tourism in
 1143 India, Malaysia and Thailand. *Tourism Management*, 58, 154-163.
- 1144 Moghimehfar, F., & Nasr-Esfahani, M. H. (2011). Decisive factors in medical tourism
 1145 destination choice: A case study of Isfahan, Iran and fertility treatments. *Tourism*
 1146 *Management*, 32(6), 1431-1434.
- 1147 Momeni, K., Janati, A., Imani, A., & Khodayari-Zarnaq, R. (2018). Barriers to the development
 1148 of medical tourism in East Azerbaijan province, Iran: A qualitative study. *Tourism*
 1149 *Management*, 69, 307-316.
- 1150 Monroe, K. B. (1990). *Pricing: Making profitable decisions*. McGraw-Hill Companies, USA.
- 1151 Musa, G., Thirumoorthi, T., & Doshi, D. (2012). Travel behaviour among inbound medical
 1152 tourists in Kuala Lumpur. *Current Issues in Tourism*, 15(6), 525-543.
- 1153 Musa, G., Doshi, D. R., Wong, K. M., & Thirumoorthy, T. (2012). How satisfied are inbound
 1154 medical tourists in Malaysia? A study on private hospitals in Kuala Lumpur. *Journal*
 1155 *of Travel & Tourism Marketing*, 29(7), 629-646.
- 1156 Nahai, F. (2009). It's procedure, not tourism. *Medical Tourism*, 1, 106.
- 1157 Oh, H. (2000). The effect of brand class, brand awareness, and price on customer value and
 1158 behavioral intentions. *Journal of Hospitality & Tourism Research*, 24(2), 136-162.
- 1159 O'Cass, A. & Sok, P. (2015). An exploratory study into managing value creation in tourism
 1160 service firms: Understanding value creation phases at the intersection of the tourism
 1161 service firm and their customers, *Tourism Management*, 51, 186-200.
- 1162 Pache, A. C., & Santos, F. (2013). Inside the hybrid organization: Selective coupling as a
 1163 response to competing institutional logics. *Academy of Management Journal*, 56(4),
 1164 972-1001.
- 1165 Parasuraman, A., Zeithaml, V., & Berry, L. (1988). SERVQUAL: A multiple-item scale for
 1166 measuring consumer perceptions of service quality. *Journal of Retailing*, 64, 12-40.
- 1167 Parasuraman, A., Berry, L. L., & Zeithaml, V. A. (1991). Perceived service quality as a
 1168 customer-based performance measure: An empirical examination of organizational
 1169 barriers using an extended service quality model. *Human Resource Management*, 30(3),
 1170 335-364.
- 1171 Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed.). Newbury Park,
 1172 CA: Sage Publications, Inc.

- 1173 Perez-Vega, R., Taheri, B., Farrington, T., & O’Gorman, K. (2018). On being attractive, social
1174 and visually appealing in social media: The effects of anthropomorphic tourism brands
1175 on Facebook fan pages. *Tourism Management*, 66, 339-347.
- 1176 Penney, K., Snyder, J., Crooks, V. A., & Johnston, R. (2011). Risk communication and
1177 informed consent in the medical tourism industry: a thematic content analysis of
1178 Canadian broker websites. *BMC medical ethics*, 12(1), 17.
- 1179 Pike, S., & Ryan, C. (2004). Destination positioning analysis through a comparison of
1180 cognitive, affective, and conative perceptions. *Journal of Travel Research*, 42(4), 333-
1181 342.
- 1182 Pike, S., & Page, S.J. (2014). Destination Marketing Organizations and destination marketing:
1183 A narrative analysis of the literature, *Tourism Management*, 41: 202-227.
- 1184 Podsakoff, P. M., MacKenzie, S. B., Lee, J. Y., & Podsakoff, N. P. (2003). Common method
1185 biases in behavioral research: A critical review of the literature and recommended
1186 remedies. *Journal of Applied Psychology*, 88(5), 879.
- 1187 Pope, J. (2008). The globalisation of medicine: the emerging market of medical tourists-
1188 estimates, challenges and prospects. In *Medical tourism: Perspectives and specific*
1189 *country experiences* (pp. 3-27). ICAFI University Press.
- 1190 Prayag, G., & Ryan, C. (2012). Antecedents of tourists’ loyalty to Mauritius: The role and
1191 influence of destination image, place attachment, personal involvement, and
1192 satisfaction. *Journal of Travel Research*, 51(3), 342-356.
- 1193 Qu, H., Kim, L. H., & Im, H. H. (2011). A model of destination branding: Integrating the
1194 concepts of the branding and destination image. *Tourism Management*, 32(3), 465-476.
- 1195 Reddy, S. G., York, V. K., & Brannon, L. A. (2010). Travel for treatment: Students’ perspective
1196 on medical tourism. *International Journal of Tourism Research*, 12(5), 510–522.
- 1197 Reed, C. M. (2008). Medical tourism. *Medical Clinics of North America*, 92(6), 1433-1446.
- 1198 Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (Eds.). (2013). *Qualitative research*
1199 *practice: A guide for social science students and researchers*. Sage, USA.
- 1200 Salanova, M., Agut, S., & Peiró, J. M. (2005). Linking organizational resources and work
1201 engagement to employee performance and customer loyalty: the mediation of service
1202 climate. *Journal of Applied Psychology*, 90(6), 1217.
- 1203 Sánchez-Fernández, R., & Iniesta-Bonillo, M. Á. (2007). The concept of perceived value: a
1204 systematic review of the research. *Marketing Theory*, 7(4), 427-451.
- 1205 Seyfi, S., & Hall, C. M. (Eds.). (2018). *Tourism in Iran: Challenges, development and issues*.
1206 Routledge.
- 1207 Skountridaki, L. (2017). Barriers to business relations between medical tourism facilitators and
1208 medical professionals. *Tourism Management*, 59, 254-266.
- 1209 Smith, R., Álvarez, M. M., & Chanda, R. (2011). Medical tourism: a review of the literature
1210 and analysis of a role for bi-lateral trade. *Health Policy*, 103(2-3), 276-282.
- 1211 Smith, P. C., & Forgione, D. A. (2007). Global outsourcing of healthcare: a medical tourism
1212 decision model. *Journal of Information Technology Case and Application*
1213 *Research*, 9(3), 19-30.
- 1214 Sweeney, J. C., & Soutar, G. N. (2001). Consumer perceived value: The development of a
1215 multiple item scale. *Journal of Retailing*, 77(2), 203-220.
- 1216 Tabachnick, B.G., & Fidell, L.S. (2013). *Using multivariate statistics (Sixth ed.)*. Boston:
1217 Pearson Education.
- 1218 Taheri, B., Jafari, A., & O’Gorman, K. (2014). Keeping your audience: Presenting a visitor
1219 engagement scale. *Tourism Management*, 42, 321-329.
- 1220 Taheri, B., Coelho, F.J., Sousa, C.M.P., & Evanschitzky, H. (2017). Mood regulation, customer
1221 participation, and customer value creation in hospitality services, *International Journal*
1222 *of Contemporary Hospitality Management*, 29 (12), 3063-3081.

- 1223 Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research: Integrating*
1224 *quantitative and qualitative approaches in the social and behavioral sciences*. Sage,
1225 USA.
- 1226 Uchida, Y. (2015). Medical Tourism or 'Medical Examination and Treatment Abroad': An
1227 Economic Study of the Phenomenon. In *Current Issues and Emerging Trends in*
1228 *Medical Tourism* (pp. 18-30). IGI Global.
- 1229 Viladrich, A., & Baron-Faust, R. (2014). Medical tourism in tango paradise: The internet
1230 branding of cosmetic surgery in Argentina. *Annals of Tourism Research*, 45, 116-131.
- 1231 Wang, H. Y. (2012). Value as a medical tourism driver. *Managing Service Quality: An*
1232 *International Journal*, 22(5), 465-491.
- 1233 Wang, C. Y., & Hsu, M. K. (2010). The relationships of destination image, satisfaction, and
1234 behavioral intentions: An integrated model. *Journal of Travel & Tourism Marketing*,
1235 27(8), 829-843.
- 1236 Wanous, J. P., Reichers, A. E., & Hudy, M. J. (1997). Overall job satisfaction: how good are
1237 single-item measures? *Journal of Applied Psychology*, 82(2), 247.
- 1238 Wardi, Y., Abror, A., & Trinanda, O. (2018). Halal tourism: antecedent of tourist's satisfaction
1239 and word of mouth (WOM). *Asia Pacific Journal of Tourism Research*, 23(5), 463-472.
- 1240 Wells, V. K., Smith, D. G., Taheri, B., Manika, D., & McCowlen, C. (2016a). An exploration
1241 of CSR development in heritage tourism. *Annals of Tourism Research*, 58, 1-17.
- 1242 Wells, V. K., Taheri, B., Gregory-Smith, D., & Manika, D. (2016b). The role of generativity
1243 and attitudes on employees' home and workplace water and energy saving
1244 behaviours. *Tourism Management*, 56, 63-74.
- 1245 Westbrook, R. A. (1987). Product/consumption-based affective responses and postpurchase
1246 processes. *Journal of Marketing Research*, 258-270.
- 1247 Williams, J., & MacKinnon, D. P. (2008). Resampling and distribution of the product methods
1248 for testing indirect effects in complex models. *Structural Equation Modeling*, 15(1),
1249 23-51.
- 1250 Wongkit, M., & McKercher, B. (2013). Toward a typology of medical tourists: A case study
1251 of Thailand. *Tourism Management*, 38, 4-12.
- 1252 Yang, Z., & Peterson, R. T. (2004). Customer perceived value, satisfaction, and loyalty: The
1253 role of switching costs. *Psychology & Marketing*, 21(10), 799-822.
- 1254 Ye, B. H., Yuen, P. P., Qiu, H. Z., & Zhang, V. H. (2008, July). Motivation of medical
1255 tourists: An exploratory case study of Hong Kong medical tourists. In *Asia Pacific*
1256 *Tourism Association (APTA) Annual Conference, Bangkok, Thailand*.
- 1257 Yeoh, E., Othman, K., & Ahmad, H. (2013). Understanding medical tourists: Word-of-mouth
1258 and viral marketing as potent marketing tools. *Tourism Management*, 34, 196-201.
- 1259 Yu, J. Y., & Ko, T. G. (2012). A cross-cultural study of perceptions of medical tourism among
1260 Chinese, Japanese and Korean tourists in Korea. *Tourism Management*, 33(1), 80-88.
- 1261 Zeithaml, V. A. (1988). Consumer perceptions of price, quality and value: A means-end model
1262 and synthesis of evidence. *Journal of Marketing*, 52, 2-2.
- 1263 Zeithaml, V. A., Berry, L. L., & Parasuraman, A. (1993). The nature and determinants of
1264 customer expectations of service. *Journal of the Academy of Marketing Science*, 21(1),
1265 1-12.
- 1266 Zeithaml, V. A., Bitner, M. J., & Gremler, D. D. (2009). *Services marketing: Integrating*
1267 *customer focus across the firm* (5th ed.). New York: McGraw-Hill/Irwin.
- 1268